

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

State of Connecticut Department of Social Services and Department of Developmental Services

Submission Date: 12/19/11

CMS Receipt Date (CMS Use) 12/19/11

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

This amendment adds the following new services, Continuous Residential Support, Parenting Support, and Senior Supports, provides more detailed descriptions of some services, and eliminates the cap on Clinical Behavioral Supports. It establishes the use of the CT Level of Need Assessment and Screening Tool to determine Level of Care. It reduces the number of slots in years 4 and 5 to more closely match the actual number of enrolled participants and reduces the number of slots targeted for high school grads. The number of participants enrolled in the waiver since 02/1/2008 has never exceeded 4000. In addition, it adjusts the utilization data and rates for some services in Appendix J for years four and five to more accurately reflect actual costs. Due to the timing of waiver years in comparison to state fiscal years slight variations in rates may occur. No current enrollees will be negatively impacted by the changes in this amendment.

State:	
Effective Date	

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

State:	
Effective Date	

1. Request Information

A. The State of **Connecticut** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (optional): Individual and Family Support Waiver (IFS)

C. Type of Request (select only one):

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	Attachment #1 contains the transition plan to the new waiver.		
<input type="radio"/>	Renewal (5 Years) of Waiver #		
<input checked="" type="radio"/>	Amendment to Waiver #	0426.R01.03-IP	

D. Type of Waiver (select only one):

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2011

E.2 Approved Effective Date (CMS Use):

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility (select applicable level of care)
<input type="radio"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="radio"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

State:	
Effective Date	

Application for a §1915(c) HCBS Waiver
HCBS Waiver Application Version 3.4

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities (*check the applicable authority or authorities*):

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input checked="" type="checkbox"/>	Not applicable		

State:	
Effective Date	

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The goals of the Individual and Family Support waiver are to provide flexible and necessary supports and services for children and adults eligible for services through the Department of Developmental Services (DDS) (formerly Department of Mental Retardation) in accordance with Section 17a-212, CT General Statutes who live in a family home or one's own home to live safe and productive lives; to support and encourage consumer-direction to maximize choice, control and efficient use of state and federal resources; and to provide a mechanism to serve an increased number of individuals through individualized and non-licensed service options such as, personal support, adult companion, respite and individualized day supports. This is a supports waiver capped at \$58,000 annually with increases when approved by the Legislature. Each individual's prospective budget allocation is determined by the assessed Level of Need (Minimal, Moderate, or Comprehensive). Additional objectives of this waiver renewal application are to include the results of the Department's CMS Independence Plus Grant through the use of the CT Level of Needs Assessment and Risk Screening Tool and new individual budgeting methodology; and, to make other administrative changes to the application that reflect lessons learned over the past 33 months as the department has fully implemented an individualized budget and fee for service system.

The Department of Social Services (DSS) is the Single State Medicaid Agency responsible for oversight of the DDS waivers. The Department of Developmental Services is the operating authority through an executed Memorandum of Understanding between the two state departments. Both departments are cabinet level agencies. DDS operates the waiver as a state operated system with state employees delivering targeted case management services, and operational functions carried out either through a central office or through one of three state regional offices. Services are delivered by an array of private service vendors through contracts or through a fee for service system; by DDS directly; and through the use of consumer-direction with waiver participants serving as the employer of record, or through the selection of an Agency with Choice model. DDS utilizes organizations to support participants who choose consumer-direction and offers support brokers as part of expanded DDS case management services or through the waiver.

Participants can utilize their allocated funds in three ways: 1) self-direction whereby funds are used to self-manage services; 2) use the funding allocation to obtain services under a rate based system from a qualified service provider; 3) use the funds to obtain services from a qualified service provider through a Purchase of Service contract. Individuals who choose to hire their own staff directly have their funds managed through a Fiscal Intermediary. Individuals who choose to have their supports provided by a qualified provider may have an authorization reimbursed through a contract or through a fiscal intermediary.

This amendment adds the following new services, Continuous Residential Support, Parenting Support, and Senior Supports, provides more detailed descriptions of some services, and eliminates the cap on Clinical Behavioral Supports. It establishes the use of the CT Level of Need Assessment and Screening Tool to determine Level of Care. It reduces the number of slots in years 4 and 5 to more closely match the actual number of enrolled participants and reduces the number of slots targeted for high school grads. The number of participants enrolled in the waiver since 02/1/2008 has never exceeded 4000. In addition, it adjusts the utilization data and rates for some services in Appendix J for years four and five to more accurately reflect actual costs. No current enrollees will be negatively impacted by the changes in this amendment.

State:	
Effective Date	

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input checked="" type="checkbox"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="checkbox"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input type="radio"/>	Yes
<input type="radio"/>	No

State:	
Effective Date	

Application for a §1915(c) HCBS Waiver
HCBS Waiver Application Version 3.4

<input checked="" type="checkbox"/>	Not applicable
-------------------------------------	----------------

- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="radio"/>	No

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

<input type="checkbox"/>	Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a

State:	
Effective Date	

reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of

State:	
Effective Date	

provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

DDS convenes the following routine meetings where public input is provided on a routine and targeted basis: Family Forums in each of the three Regions on a quarterly basis; Provider Leadership Forums in each of the three Regions on a quarterly basis; and Provider Trades Association meetings with the Commissioner on a bi-monthly basis. Additional public input is gained through targeted information and discussion tables at meetings and events held throughout the state such as self-

State:	
Effective Date	

advocacy supported employment events, provider conferences and cultural events for example; through publication and solicitation of input requests through the stakeholder mailing *Direct to Families*; through posting on the DDS web site; through publication in the CT Law Journal; and through a legislative public hearing.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Kathy
Last Name	Bruni
Title:	Social Services Medical Administrative Program Manager
Agency:	Department of Social Services
Address 1:	25 Sigourney Street
Address 2:	
City	Hartford
State	CT
Zip Code	06106
Telephone:	1-860-424-5177
E-mail	kathy.a.bruni@ct.gov
Fax Number	1-860-424-4963

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Krista
Last Name	Pender
Title:	Fiscal Administrative Manager
Agency:	Department of Developmental Services
Address 1:	460 Capitol Avenue
Address 2	
City	Hartford

State:	
Effective Date	

Application for a §1915(c) HCBS Waiver
HCBS Waiver Application Version 3.4

State	CT
Zip Code	06106
Telephone:	860-418-6109
E-mail	krista.pender@ct.gov
Fax Number	860-622-2641

State:	
Effective Date	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____

Date: _____

State Medicaid Director or Designee

First Name:	Mark
Last Name	Schaeffer
Title:	Medical Care Administration Director
Agency:	Department of Social Services
Address 1:	25 Sigourney Street
Address 2:	
City	Hartford
State	CT
Zip Code	06106
Telephone:	860-424-5067
E-mail	mark.schaeffer@ct.gov
Fax Number	860-424-4963

State:	
Effective Date	

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Department of Mental Retardation was officially changed to the Department of Developmental Services on October 1, 2007. References to official documents such as regulations, policies, procedures, or web links contained in this waiver may still be listed as DMR rather than DDS.

Amendment 1 changed in the name of and the provider qualifications for Supported Living and IS Habilitation. These services have been combined into a service named Individualized Home Supports. In addition, the service called Consultation in the approved waiver was eliminated in this amendment. The supports that were offered under Consultation were separated into Nutrition and Clinical Behavioral Supports.

Amendment 1 contains some new services as well. The new services are Adult Day Health, Community Training Home, Live-in Caregiver, Individual Goods and Services and Health Care Coordination. Participants will receive a fact sheet describing the new services at the time of his/her next Individual Planning meeting and may choose to change or add services at that time. Information regarding the new service options will be available through the DDS case manager, Regional Offices and on the DDS web site. A participant may notify DDS that he/she wishes to change service selections prior to the next scheduled meeting if desired. In those cases, DDS will schedule a team meeting within 30 days to review the new service options and develop a new Individual Plan if desired.

Amendment 1 also contains new funding methodologies for individual service budgets. Current authorized service budgets will remain unchanged by the changes to the funding methodology through this renewal application. Requests for new or additional services by current participants received after the renewal date of this waiver will be subject to the requirements outlined in this application.

Amendment 2 reduces the total number of slots and targets slots for specific purposes.

This amendment adds three new services, Continuous Residential Support, Parenting Support, and Senior Supports, provides more detailed descriptions of some services, and eliminates the cap on Clinical Behavioral Supports. It establishes the use of the CT Level of Need Assessment and Screening Tool to determine Level of Care. It reduces the number of slots in years 4 and 5 to more closely match the actual number of enrolled participants. The number of participants enrolled in the waiver since 10/1/2008 has never exceeded 4000. In addition, it adjusts the utilization data and rates for some services in Appendix J for years four and five to more accurately reflect actual costs. No current enrollees will be negatively impacted by the changes in this amendment.

State:	
Effective Date	

Appendix B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both (<i>select one</i>)			
<input type="radio"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
	<input type="checkbox"/>	Aged (age 65 and older)		<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical) (under age 65)		
	<input type="checkbox"/>	Disabled (Other) (under age 65)		
	Specific Recognized Subgroups (<i>check each that applies</i>)			
	<input type="checkbox"/>	Brain Injury		<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS		<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile		<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent		<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation or Developmental Disability, or Both (<i>check each that applies</i>)		
<input type="checkbox"/>	Autism		<input type="checkbox"/>	
<input checked="" type="checkbox"/>	Developmental Disability	18 years		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation	3 years		<input checked="" type="checkbox"/>
<input type="radio"/>	Mental Illness (<i>check each that applies</i>)			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Eligibility for services from the Department of Developmental Services is based on CGS 1-1g which requires eligible individuals to have an IQ of 69 or lower concurrent with deficits in adaptive behavior during the developmental period.

Also included are those determined eligible for DDS services as a result of a hearing conducted by DDS according to the Uniform Administrative Procedures Act or administrative determination of the Commissioner.

Developmental Disability as a target group is limited to individuals who are developmentally disabled who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

Additional Criteria to designate the target group is living arrangement. The individual must reside in a family home, in his/her own home, licensed Community Training Home, or in a home where Continuous Residential Supports are provided to be enrolled in the IFS waiver.

State:	
Effective Date	

Appendix B: Participant Access and Eligibility
HCBS Waiver Application Version 3.4

--

- c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

<input type="checkbox"/>	Not applicable – There is no maximum age limit
<input type="radio"/>	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (<i>specify</i>):

State:	
Effective Date	

Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

<input type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>
<input type="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):
<input type="radio"/>	% , a level higher than 100% of the institutional average
<input type="radio"/>	Other (<i>specify</i>):
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>
<input checked="" type="checkbox"/>	<p>Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i></p> <p>The individuals who will be supported by this waiver are reflective of the current population served by DDS but may have less comprehensive support needs than some other participants and or may have many more natural or informal supports available to them that enable them to take advantage of the flexibility and variety of service options in this waiver in order to remain in their own or family home. These factors and the flexibility and variety of waiver services offered will allow individuals to be effectively supported by a waiver with a more limited benefit package.</p> <p>Most individuals in this waiver will not require paid 24 hour care or supervision as a waiver service as a result of the natural or informal supports in place or as a result of the individual's level of supervision needs. The exception to this are people who choose to live in Community Training Homes which are licensed family homes where 24 hour support is available. Providers of this service receive a monthly stipend for providing care for each of the participants living in their home. In most cases individuals living in Community Training Homes also receive additional funding for day services, respite, transportation or other needs identified in their Individual Plan.</p> <p>Each individual receives a prospective funding allocation based on their support needs as identified by the CT Level of Need Assessment and Screening Tool. Once the Individual Plan has been developed and available natural supports, state plan services and required waiver services are identified the individual budget is finalized.</p>

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

	The cost limit specified by the State is (<i>select one</i>):		
	<input checked="" type="checkbox"/>	The following dollar amount: \$	\$58,000
		The dollar amount (<i>select one</i>):	
	<input type="checkbox"/>	Is adjusted each year that the waiver is in effect by applying the following formula:	
	<input checked="" type="checkbox"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.	
	<input type="checkbox"/>	The following percentage that is less than 100% of the institutional average:	%
	<input type="checkbox"/>	Other – <i>Specify</i> :	

State:	
Effective Date	

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The team submits a request for services to the Regional Planning and Allocation Team. Based on the findings of the LON Assessment, the PRAT notifies the team of the funding allocations. The team initiates the Individual Planning process in advance of enrollment in a DDS waiver. If the team determines that the initial allocation is insufficient to meet the individual's needs, the team submits a request for utilization review to the PRAT for consideration. The PRAT determines if a higher funding amount is justified and if the funding amount falls within the overall limits of the IFS waiver. If approved, the participant will complete enrollment in the IFS waiver and the Individual Plan is processed for service authorizations to initiate services. If the PRAT does not approve the higher funding request, the individual is provided opportunity to informally negotiate a resolution and is simultaneously notified of his/her fair hearing rights as a result of being denied enrollment in the DDS IFS waiver.

If the PRAT agrees the individual requires higher funding than is permitted in the IFS waiver prior to enrollment, the PRAT will consider the individual for eligibility in the DDS Comprehensive Support waiver following DDS priority procedures in the management of the DDS waiting list.

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input checked="" type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input checked="" type="checkbox"/>	<p>Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:</p> <p>The case manager submits to the PRAT a request for additional services/funding and an updated Level of Need Assessment supporting the request. The PRAT may authorize funding up to the amount associated with the participant's newly determined Level of Need. If the request exceeds the overall limit of the IFS waiver, the PRAT may authorize funding up to \$20,000 more than the IFS waiver limit on a non-annualized basis to meet the participant's immediate needs while other alternatives are coordinated or to meet emergency needs that are not expected to be long-term (i.e. enhanced supports due acute medical needs of the participant, or a temporary change in the capacity of natural supports).</p>
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

Appendix B-3: Number of Individuals Served

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	4018
Year 2	4468
Year 3	4468
Year 4 (renewal only)	4100
Year 5 (renewal only)	4150

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

<input checked="" type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

- c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.	
<input checked="" type="checkbox"/>	<p>The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:</p> <p>High School Graduates—The number of reserved slots is based on historical data regarding the average number of high school grads whose needs can be met through the provision of services and funding cap offered in this waiver.</p> <p>Age-outs--are individuals who are turning 21 and aging out of residential services funded by the LEA or the DDS/DCF Voluntary Services Program. The number of reserved slots is based on historical data regarding the average number of these individuals whose needs can be met through the provision of services and funding cap offered in this waiver.</p> <p>Children newly enrolled in the Voluntary Services Program (VSP)—are children with significant behavioral support needs who require waiver services in order to be successful living in their family home and participating in community activities. The number of reserved slots is based on historical data regarding the average number of these individuals whose needs can be met through the provision of services and funding cap offered in this waiver.</p> <p>Emergencies--People who have been determined to be in need of immediate waiver services either in or out of home.</p>	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
		Purpose:
		Purpose:
		High School Grads
		Age-Outs
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3	100	10
Year 4 (renewal only)	50	10
Year 5 (renewal only)	50	10
	Purpose:	Purpose:
		Voluntary Services Program
		Emergencies
Waiver Year	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3	20	

State:	
Effective Date	

Appendix B: Participant Access and Eligibility
HCBS Waiver Application Version 3.4

Year 4 (renewal only)	20	20
Year 5 (renewal only)	20	20

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

<p>The State DDS uses a priority system to select individuals for entrance to the DDS waivers. The DDS utilizes a Priority Checklist that incorporates findings from the Level of Needs Assessment and Risk Screening Tool and collects findings on additional questions pertaining to individual and caregiver status. The system assigns an Emergency, Priority 1 or Planning status as a result of the screening tools. Those identified as an Emergency are given first priority to the appropriate waiver program when slots are available. The Priority 1 group is afforded the next priority. Individuals in the groups targeted for reserved slots (Emergency, grads, age-outs and children in VSP) fall within the Priority 1 status and are assigned to one of the reserved slots. Those with elderly caregivers (age 65 and above) are given the next priority within the Priority 1 sub-set. All other applicants are managed on a first come first serve basis. Individuals who are dissatisfied with priority assignment may submit a request in writing to the Commissioner of DDS for an administrative hearing pursuant to sub-section (e), section 17a-210, G.S., or, may initiate an informal dispute resolution process, Programmatic Administrative Review (PAR) set forth in DMR Policy 7 (1986). Individuals who request a PAR may also request a Fair Hearing at any time.</p>
--

State:	
Effective Date	

Waiver Phase-In/Phase Out Schedule

- | | |
|-----------------------|------------|
| <input type="radio"/> | Phased-in |
| <input type="radio"/> | Phased-out |

- | Year One | Year Two | Year Three | Year Four | Your Five |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Month | Waiver Year |
|-----------------------------------|-------|-------------|
| Waiver Year: First Calendar Month | | |
| Phase-in/Phase out begins | | |
| Phase-in/Phase out ends | | |

- [illegible]

State:	
Effective Date	

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. **State Classification.** The State is a (*select one*):

<input type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input checked="" type="radio"/>	209(b) State

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input type="checkbox"/>	SSI recipients
<input checked="" type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input type="checkbox"/>	Medically needy
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> : <u>Persons defined as qualified severely impaired individuals in section 1619(b) and 1905(q) of the Social Security Act</u>
Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
<input type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
<input checked="" type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

<input type="radio"/>		All individuals in the special home and community-based waiver group under 42 CFR §435.217	
<input checked="" type="checkbox"/>		Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):	
	<input checked="" type="checkbox"/>	A special income level equal to (select one):	
		<input checked="" type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)
		<input type="radio"/>	% of FBR, which is lower than 300% (42 CFR §435.236)
		<input type="radio"/>	\$ which is lower than 300%
	<input checked="" type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
	<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
	<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
	<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)	
		<input type="radio"/>	100% of FPL
		<input type="radio"/>	% of FPL, which is lower than 100%
	<input type="radio"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :	

State:	
Effective Date	

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

<input checked="" type="checkbox"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input checked="" type="checkbox"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="checkbox"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="checkbox"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

- b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State.** The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):	
<input type="checkbox"/>	The following standard included under the State plan (<i>select one</i>):
<input type="checkbox"/>	SSI standard
<input type="checkbox"/>	Optional State supplement standard
<input type="checkbox"/>	Medically needy income standard
<input type="checkbox"/>	The special income level for institutionalized persons (<i>select one</i>):
<input type="checkbox"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	% of the FBR, which is less than 300%
<input type="checkbox"/>	\$ which is less than 300%.
<input type="checkbox"/>	of the Federal poverty level
<input type="checkbox"/>	Other (specify):
<input type="checkbox"/>	

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (see instructions)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (see instructions)		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:			
<input type="radio"/>	Not applicable (see instructions)		
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (specify):		

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

- c-1. Regular Post-Eligibility: 209(b) State.** The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one)</i> :			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
<input type="radio"/>	<input type="radio"/>	The following standard under 42 CFR §435.121:	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i>	
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>		of the FBR, which is less than 300%
	<input type="radio"/>	\$	which is less than 300% of the FBR
	<input type="radio"/>		of the Federal poverty level
	<input type="radio"/>	Other (specify):	
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only <i>(select one)</i> :			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable <i>(see instructions)</i>		
iii. Allowance for the family <i>(select one)</i>			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

<input type="radio"/>	
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:
<input type="radio"/>	Other (specify):
<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

State:	
Effective Date	

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>		
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input type="radio"/>	The special income level for institutionalized persons <i>(select one):</i>
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
	<input type="radio"/>	% of the FBR, which is less than 300%
	<input type="radio"/>	\$ which is less than 300%.
	<input type="radio"/>	% of the Federal poverty level
	<input type="radio"/>	Other (specify):
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only <i>(select one):</i>		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:	
	<input type="radio"/>	SSI standard
	<input type="radio"/>	Optional State supplement standard
	<input type="radio"/>	Medically needy income standard
	<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.
	<input type="radio"/>	The amount is determined using the following formula:
<input type="radio"/>	Not applicable <i>(see instructions)</i>	

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

iii. Allowance for the family <i>(select one):</i>	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
<input type="radio"/>	Other <i>(specify)</i> : <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
<input type="radio"/>	Not applicable <i>(see instructions)</i>
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable <i>(see instructions)</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits <i>(specify)</i> : <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>	
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>
<input type="radio"/>	The following standard under 42 CFR §435.121: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
<input type="radio"/>	Optional State supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i>
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	<div style="border: 1px solid black; display: inline-block; width: 50px; height: 20px; vertical-align: middle;"></div> of the FBR, which is less than 300%

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

	<input type="radio"/>	\$	which is less than 300% of the FBR
	<input type="radio"/>		of the Federal poverty level
	<input type="radio"/>	Other (specify):	
	<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
	<input checked="" type="checkbox"/>	The following formula is used to determine the needs allowance:	
		200% of the Federal Poverty Level	
ii. Allowance for the spouse only (select one):			
	<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
	Specify the amount of the allowance:		
	<input type="radio"/>	The following standard under 42 CFR §435.121:	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
	<input type="radio"/>	The amount is determined using the following formula:	
	<input checked="" type="checkbox"/>	Not applicable (see instructions)	
iii. Allowance for the family (select one)			
	<input type="radio"/>	AFDC need standard	
	<input checked="" type="checkbox"/>	Medically needy income standard	
	<input type="radio"/>	The following dollar amount:	\$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
	<input type="radio"/>	The amount is determined using the following formula:	
	<input type="radio"/>	Other (specify):	

State:	
Effective Date	

Appendix B: Participant Access and Eligibility
HCBS Waiver Application Version 3.4

<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input checked="" type="checkbox"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

State:	
Effective Date	

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input checked="" type="checkbox"/>	200 %	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (<i>specify</i>):	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one</i> :		
<input checked="" type="checkbox"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one</i> :		
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
<input checked="" type="checkbox"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> :
	1
ii.	Frequency of services. The State requires <i>(select one)</i> :
	<input type="radio"/> The provision of waiver services at least monthly
	<input checked="" type="checkbox"/> Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
	Waiver services shall be provided at least once per year. The Case Manager will provide monitoring to assure health and welfare in the months the services is not provided and record in a monthly case management note in the individual record.

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed *(select one)*:

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="checkbox"/>	By the operating agency specified in Appendix A
<input type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
<input type="radio"/>	Other <i>(specify)</i> :

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Case managers, CM Supervisors, DDS managers or clinicians who meet the following QMRP standards:
An individual who has received: at least a bachelor's degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a major or minor coursework concentration in a human services field. "Human services field" includes all any academic

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

disciplines associated with the study of: human behavior (e.g., psychology, sociology, speech communication, gerontology etc.), human skill development (e.g., education, counseling, human development), humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g., rehabilitation counseling), or the human condition (e.g., literature, the arts) and who has demonstrated competency to do the job.

All DDS Case Managers are required to pass an exam (score of 70 or better) that focuses on knowledge, skills, and abilities. Ongoing competency is evaluated through supervision, training and oversight provided by a Supervisor of Case Management and Annual Performance Review is required for all case managers.

State:	
Effective Date	

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

There is reasonable indication that the person, but for the provision of waiver services would require placement in an ICF/MR.

The person requires assistance due to one or more of the following:

1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative support in performing self-care and daily activities.
2. Has a deficit in self-care and daily living skills requiring habilitative training.
3. Has a maladaptive social and/or interpersonal pattern to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training.

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is be used to validate the participant's Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/MR Level of Care. The scoring algorithm used to calculate the Composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is be used to validate the participant's Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/MR Level of Care. The scoring algorithm used to calculate the Composite score incorporates the scores from the domains listed above

State:	
Effective Date	

Appendix B: Participant Access and Eligibility

HCBS Waiver Application Version 3.4

and results in an overall score ranging from 1 to 8. The DDS case manager with the Individual Support Team completes the initial, or reviews the existing, CT LON assessment and makes updates as required by changes in the individual. The score on the CT LON determines whether or not the participant meets, or continues to meet, the ICF/MR Level of Care.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The CT automated consumer information system (CAMRIS) maintains the date of the last Individual Annual Plan review. The Level of Care determination is completed at the time of each review. The case manager and case manager supervisor use this system as a tickler system.

Individual Plan data is reviewed quarterly by Central Office staff and distributed to appropriate regional staff with a timeframe for correction. In addition, Supervisors of Case Management conduct Quality Service Reviews (QSR) which include evaluation of the timeliness of the Individual Plan, including the Level of Care determination. If the QSR identifies that the LOC is either not completed or not current a corrective action plan (CAP) is developed with specific follow-up and timeframes provided. The QSR computer application tracks these CAPs.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and re-evaluations are available in the DDS case management record and/or the web-based CT LON application. The initial evaluations are also maintained in the individual's DSS records on the Waiver Enrollment Form 219 or 219e.

State:	
Effective Date	

Appendix B: Participant Access and Eligibility
HCBS Waiver Application Version 3.4

State:	
Effective Date	

Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals seeking services from DDS are notified of the alternatives available under the waiver and are informed of their option to choose institutional or waiver services by the DDS case manager. This decision is documented on Form 222, Service Selection Form. The State provides individuals with the HCBS waiver Fact Sheet, and with the Guide to Understanding the DDS HCBS Waivers for Individuals and Families at the annual planning meeting, and both are available on the DDS web site.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

DDS case management record and DSS record.

State:	
Effective Date	

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

The State DDS prepares HCBS waiver informational materials in English and Spanish and posts both to the DDS web site. Additionally, the DDS utilizes a *Language Line* service to ensure that all individuals who call the DDS at the central office or Regional locations will have language interpreter service immediately upon the call. DDS policy states that language interpretation service will be provided free of charge at all intake, formal planning meetings, hearings or informal dispute resolution process sessions. Once enrolled in an HCBS waiver, interpreter services are also included as a covered waiver service for other purposes as detailed in the plan.

State:	
Effective Date	

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

- a. Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input checked="" type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input checked="" type="checkbox"/>	Individualized Home Supports, Residential Habilitation CTH, Continuous Residential Supports
Day Habilitation	<input checked="" type="checkbox"/>	Group and Individualized Day Supports
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input checked="" type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input checked="" type="checkbox"/>	Live-in Companion
Other Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (list each service by title):	
a.	Adult Companion	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

b.	Behavioral Support Services	
c.	Family Training	
d.	Health Care Coordination	
e.	Individual Goods and Services	
f.	Interpreter Services	
g.	Nutrition	
h.	Parenting Support	
i.	Personal Emergency Response System	
j.	Personal Support	
k.	Senior Supports	
l.	Specialized Medical Equipment and Supplies	
m.	Transportation	
n.	Vehicle Modifications	
o.	Environmental Modifications	
Extended State Plan Services <i>(select one)</i>		
<input checked="" type="checkbox"/>	Not applicable	
<input type="checkbox"/>	The following extended State plan services are provided <i>(list each extended State plan service by service title)</i> :	
a.		
b.		
c.		
Supports for Participant Direction <i>(select one)</i>		
<input checked="" type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.	
<input type="checkbox"/>	Not applicable	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<input checked="" type="checkbox"/>	Independent Support Broker (formerly FICS)
Financial Management Services	<input type="checkbox"/>	
Other Supports for Participant Direction <i>(list each support by service title)</i> :		
a.		
b.		

State:	
Effective Date	

Appendix C: Participant Services
 HCBS Waiver Application Version 3.4

c.

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

<input checked="" type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State of CT DDS.

State:	
Effective Date	

Appendix C-2: General Service Specifications

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

- **Yes.** Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Direct Support and professional support services under the following service definitions are required to submit to state (CT) only criminal checks. This includes all staff employed under clinical behavioral supports, family training, individualized home support, Community Training Homes, Continuous Residential Support, group and individualized day services, senior supports, supported employment, adult companion, personal support, respite, live-in caregivers, individual goods and services, independent support brokers, interpreters, and transportation vendors not licensed as a livery service in the state of CT. Vendors enrolled as PERS, vehicle modifications, Environmental modifications, or specialized medical and adaptive equipment are not required to submit to criminal background checks.

The process for ensuring that mandatory investigations have been completed depends upon the service and the hiring entity. The Fiscal Intermediary is required to obtain a criminal background check for any service vendor hired through the consumer-directed process prior to processing any employment paperwork or permitting the employee to begin work. DDS conducts annual FI audits for consumer-directed services to ensure that the required criminal background checks are conducted. For DDS delivered services, the HR department is responsible to ensure all employees have successfully completed criminal background checks. For individually enrolled vendors, criminal background checks are required to enroll in the DDS HCBS waiver program and receive a provider agreement. For services operated by larger provider agencies, the provider agency agrees to obtain a criminal background check for any individual who provides the specified services as part of the Medicaid Provider Agreement. When an incident involving abuse/neglect or other misconduct by an employee reveals that the employee has a criminal history DDS Policy requires that DDS conducts an inquiry into the provider agency's compliance with conducting criminal background checks.

No. Criminal history and/or background investigations are not required.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

- **Yes.** The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

<input type="radio"/>	<p>DDS maintains an abuse/neglect registry pursuant to CT General Statutes 17a-247a-17a-247e. All employees of DDS or agencies funded or licensed by DDS who are found guilty of abuse and terminated or separated from employment are subject to inclusion on the registry. This is required to ensure the abuse/neglect registry has been checked for all individual employees sought to be hired through consumer-direction. The DDS and private provider is required to check the registry prior to hiring any employee who will deliver services. The DDS monitors this expectation during annual FI audits and at the provider level through bi-annual Quality Service Reviews conducted by DDS,</p>
<input type="radio"/>	<p>No. The State does not conduct abuse registry screening.</p>

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

<input type="radio"/>	<p>No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i></p>
<input checked="" type="radio"/>	<p>Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Complete Items C-2-c.i – c.iii.</i></p>

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Community Training Home	Residential Habilitation CTH	3

State:	
Effective Date	

Appendix C: Participant Services
 HCBS Waiver Application Version 3.4

- ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

- iii. Scope of Facility Standards.** By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type	Facility Type
	Residential Habilitation-- CTH			
Admission policies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

For individuals living in Community Training Homes the individual's team will review the medication regimen when developing the Individual Plan. The review will be based on anecdotal information, observation, or other method if identified by the team. The medication regimen will be reviewed quarterly with the review of the Individual Plan. The individual's Primary Care Physician will review their current plan of care at their annual physical exam and any subsequent visits.

State:	
Effective Date	

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

<input type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

	<p>Requests to permit payment to relatives/legal guardians for furnishing the following waiver services: Individualized Home Supports, Individualized Day Supports, Supported Employment, Respite, Adult Companion, Personal Support, and Transportation are only permitted under consumer directed services, and must be approved by the DDS prior approval committee. This committee ensures that the provision of service is in the best interest of the participant. Additional requirements include the use of a Support Broker to ensure that the individual has engaged in recruitment activities and that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities. Circumstances where this may be permitted are limited to relatives/legal guardians who possess the medical skills necessary to safely support the individual, or, when the Prior Approval Committee determines that qualified staff is otherwise not available. Payment to family members is only made when the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family; and, the service would otherwise need to be provided by a qualified provider. The responsible person can be an attorney, a member of the circle of support, friend or advocate who is willing to take on the responsibility of reviewing the timesheets and verifying that the services were provided.</p> <p>Relatives, or legal guardians who reside with an individual cannot be hired to provide a waiver service when:</p> <ul style="list-style-type: none"> • The relative/legal guardian is the sole legal guardian of the individual • The relative/legal guardian is the legally responsible relative of the individual • The relative/legal guardian is the employer of record • The relative/legal guardian is the parent of a child under 18 who is receiving the service. <p>Relatives, or legal guardians who reside with an individual who do not meet the exclusionary criteria above can be considered for hire when:</p> <ul style="list-style-type: none"> • The service would otherwise need to be provided by a qualified provider • A qualified provider who is not a family member/legal guardian is not available to provide the service or can only provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member; and • The planning team determines the family member providing the support will best meet the individual's needs.
○	<p>Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i></p>
○	<p>Other policy. <i>Specify:</i></p>

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All information regarding requirements for and instructions to enroll as a qualified provider for the

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

DDS HCBS waivers is posted to the DDS web site. DDS completes the evaluation of qualified providers and notifies DSS for final provider enrollment. Any provider of services may submit an application for enrollment to the DDS Operation Center for any service at any time.

State:	
Effective Date	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Individualized Home Supports (formerly Supported Living or Individual Habilitation)		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
This service provides assistance with the acquisition, improvement and/or retention of skills and provides necessary support to achieve personal habilitation outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service includes a combination of habilitation and personal support activities as they would naturally occur during the course of a day. This service is not available for use in licensed settings. The service may be delivered in a personal home (one's own or family home) and in the community. Payments for Individualized Support do not include room and board. May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Respite, Personal Support, Adult Companion, Continuous Residential Support and/or Individualized Goods and Services.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Individuals hired by participants who self direct	Private agency or DDS
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired by participants who self direct			The FI will verify that employees meet the following qualifications: Prior to Employment <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>individual/family</p> <ul style="list-style-type: none"> • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the team if requested by the individual • demonstrate understanding of Person Centered Planning • demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans* • Medication Administration* <p>* if required by the individual supported</p>
Private Provider or DDS			<p>The agency will ensure that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>keeping as required by the employer</p> <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the team if requested by the individual • demonstrate understanding of Person Centered Planning • demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans* • Medication Administration* <p>* if required by the individual supported</p>
--	--	--	--

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired by participants who self direct	FI	Prior to Employment
	DDS	Annual sample of participant-directed persons
Private Provider or DDS	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
--	-------------------------------------	---	-------------------------------------	------------------

Service Specification			
Service Title:	Continuous Residential Supports		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input checked="" type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>This service provides assistance with the acquisition, improvement and/or retention of skills and provides necessary support to achieve personal habilitation outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service includes a combination of habilitation and personal support activities as they would naturally occur during the course of a day.</p> <p>Continuous residential supports must take place in a setting other than a family home and have the following:</p> <ul style="list-style-type: none"> • Three or fewer participants living together in the same apartment, condominium or single family dwelling • Readily available third shift staff awake or asleep. Readily available means in the same setting or adjoining setting such as a two or three family, duplex, side by side condos. • Supports available throughout non-work hours though some time alone as approved by the team would be allowed. • Some individuals could require intermittent staff support but live in the same apartment or single family dwelling where continuous supports are provided to other people living there. • This service is not available for use in licensed settings. <p>Individuals who wish to self-direct their services may do so by utilizing an Agency with Choice. (See Appendix E-2 a i. For more information)</p> <p>Payments for Continuous Residential Support do not include room and board. May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Respite, Personal Support, Adult Companion, Individualized Home Support and/or Individualized Goods and Services.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="radio"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Private agency or DDS
			Agency with Choice
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Private Provider or DDS			The agency will ensure that employees meet the following qualifications: Prior to Employment

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the team if requested by the individual • demonstrate understanding of Person Centered Planning • demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans* • Medication Administration* <p>* if required by the individual supported</p>
--	--	--	---

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Private Provider or DDS	DDS	Initial and every 2 years certification thereafter

State:	
Effective Date	

Appendix C: Participant Services
 HCBS Waiver Application Version 3.4

Service Delivery Method			
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Residential Habilitation (Community Training Homes)		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Assist with the acquisition, improvement and /or retention of skills and provide necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in their Individual Plan. This service is specifically designed to result in learned outcomes, but can also include elements of personal support that occur naturally during the course of the day. Examples of the type of support that may occur in these settings include:</p> <ul style="list-style-type: none"> • Provision of instruction and training in one or more need areas to enhance the individual's ability to access and use the community; • Implement strategies to address behavioral, medical or other needs identified in the Individual Plan; • Implement all therapeutic recommendations including Speech, O.T., P.T., and assist in following special diets and other therapeutic routines; • Mobility training; • Adaptive communication training; • Training or practice in basic consumer skills such as shopping or banking; and, • Assisting the individual with all personal care activities. <p>Provision of these services is limited to licensed CTH settings. Payments for residential habilitation in these settings do not include room and board, the cost of facility maintenance, upkeep or improvement. This service may not be used in combination with Individualized Home Supports, Personal Support, Adult Companion, or Continuous Residential Supports.</p> <p>Not included in the payment for services in CTHs is an average of 30 hours per week when it is expected that participants will be receiving Group Day Supports, Individualized Day Supports, Supported Employment, or Adult Day Health services.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/> Agency. List the types of agencies:
		Individuals licensed as Community Training Home Providers	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Individuals licensed as Community Training Home Providers	Licensed as a Community Training Home provider		<p>Prior to Employment</p> <ul style="list-style-type: none"> • 21 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of Person Centered Planning • demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans* <p>*if required by the participant</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individuals licensed as Community Training	DDS		Initial and annual licensing thereafter

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Home Providers					
Service Delivery Method					
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed	

Service Title:	Group Day Supports				
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>					
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.				
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.				
<input type="radio"/>	Service is not included in the approved waiver.				
Service Definition (Scope):					
Services and supports leading to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure and retirement activities. This service is provided by a qualified vendor in a facility-based program or appropriate community locations. Transportation to and from home is included as part of this waiver service. The agency rate is adjusted for transportation costs based on mileage and type of vehicle required. May not be provided at the same time as Individualized Day Supports, Supported Employment, Respite, Personal Support, Individualized Home Supports, Continuous Residential Supports, or Adult Companion.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
This service is limited to no more than 8 hours per day.					
Provider Specifications					
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
				DDS or Private Provider	
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):					
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)		
DDS or Private Provider			The agency will ensure that employees meet the following qualifications : Prior to Employment <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer 		

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of Person Centered Planning • Medication Administration* <p>* if required by the individual supported</p>
--	--	--	--

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
DDS or Private Provider	DDS	Initial and every 2 years certification thereafter
Service Delivery Method		
Service Delivery Method (check each that applies):	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Individualized Day Support
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Services and supports provided to individuals tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support an individual for work	

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

and/or community participation and/or meaningful retirement activities, or for an individual who has their own business, and could not do so without this direct support. The service begins and ends at the participant's home and all transportation is included as part of the service rate. This service is not delivered in or from a facility-based program. This service may be self directed or provided by a qualified agency. May not be provided at the same time as Group Day, Supported Employment, Respite, Personal Support, Adult Companion, or Individualized Home Supports

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 8 hours per day.

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals hired by participants who self direct		Private Provider
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 21 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>Individual Plan</p> <ul style="list-style-type: none"> • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the team if requested by the individual • demonstrate understanding of Person Centered Planning • Medication Administration* <p>* if required by the individual supported</p>
Private Provider			<p>The agency ensures that employees meet the following qualifications :</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 21 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			Person Centered Planning • Medication Administration* * if required by the individual supported
--	--	--	---

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired by participants who self direct	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons
DDS Qualified Provider	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
--	--------------------------	---	--------------------------	------------------

Service Title:	Supported Employment
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

Service Definition (Scope):

Supported Employment consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their disabilities, need supports to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to obtain and sustain paid work by participants, including career planning, job development, supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Supported employment does not include sheltered work or similar types of vocational services furnished in specialized facilities. Supported employment services may be furnished to participants who are paid at a rate more than minimum wage, provided that the participant requires supported employment services in order to sustain employment. Supported employment services may be furnished by a co-worker or other sob-site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and those individuals meet the pertinent qualifications for providers of the service. Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

2. Payments that are passed through to users of supported employment programs; 3. Payments for vocational training that is not directly related to a participant's supported employment. Supported employment services furnished under the waiver are not available under a program funded by either program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. May not be provided at the same time as Group Day Supports, Individualized Day Supports, Individualized Home Supports, Respite, Personal Support, or Adult Companion.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
This service is limited to no more than 8 hours per day or 40 hours per week.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals hired by participants who self direct		DDS or Private Providers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Individuals hired by participants who self direct			The FI will verify that employees meet the following qualifications: Prior to Employment <ul style="list-style-type: none"> 21 years of age criminal background check registry check have ability to communicate effectively with the individual/family have ability to complete record keeping as required by the employer Prior to being alone with the individual <ul style="list-style-type: none"> demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse. demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan demonstrate competence, skills, abilities, education and/or 	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>experience necessary to achieve the specific outcomes as described in the IP</p> <ul style="list-style-type: none"> • ability to participate as a member of the circle if requested by the individual • Medication Administration* <p>* if required by the individual supported</p>
DDS or Private Provider			<p>The agency ensures that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 21 years of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the individual</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse. • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP • ability to participate as a member of the circle if requested by the individual • Medication Administration* <p>* if required by the individual supported</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired by participants who self direct	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

DDS or Private Provider	DDS	Initial and every 2 years certification thereafter
Service Delivery Method		
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Respite		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care will be provided in the following location(s):</p> <p>Individual's home or place of residence; DDS certified respite care facility; DDS certified residential camp program. May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Senior Supports, Personal Support, Adult Companion, or Individualized Home Supports.</p> <p>This service is not available to individuals who receive Continuous Residential Supports.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Respite may be provided for up to 30 consecutive days. Respite services beyond 30 consecutive days will require approval from DDS.			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Individuals hired by participants who self direct	DDS or Private Providers
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment</p> <p>In Home Respite</p> <ul style="list-style-type: none"> • 16 yrs of age • have ability to communicate effectively with the

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>individual/family</p> <ul style="list-style-type: none"> • have ability to complete record keeping as required by the employer <p>Out of home respite</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>In Home and Out of Home</p> <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans* • Medication Administration* <p>* if required by the individual supported</p>
DDS or Private Provider		Facilities and/or entities and individuals certified in accordance with subsection (d) of Section 17a-218, the regulations promulgated there under, or otherwise certified as a “qualified provider” of respite services	<p>The agency ensures that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

		by DDS and Reg. Conn. Agencies-DMR Sections 17a-218-8 through 17a-218-17 (The “Respite Regs”)	<p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans* • Medication Administration* <p>* if required by the individual supported</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual hired by participants who self direct	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons
DDS or Private Provider	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
--	--------------------------	---	--------------------------	------------------

Service Title:	Live-in Companion
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Service Definition (Scope):			
When a waiver service such as Individualized Home Supports or Personal Support is provided by an unrelated, live-in caregiver, funding is available to cover the additional costs of rent and food that can be reasonably attributed to the unrelated live-in personal caregiver who resides in the same household as the waiver participant. The reimbursement for the increased rental costs will be based on the DDS Rent Subsidy Guidelines and will follow the limits established in those guidelines for rental costs. The reimbursement for food costs will be based on the USDA Moderate Food Plan Cost averages. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/> Agency. List the types of agencies:
	Individuals		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals			<p>The FI will verify that live in companions meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> 21 yrs of age criminal background check registry check have ability to communicate effectively with the individual/family have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques demonstrate competence/knowledge in topics required safely support the individual as described in the Individual Plan demonstrate competence, skills, abilities, education and/or experience necessary to achieve the

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			specific training outcomes as described in the Individual Plan <ul style="list-style-type: none"> • ability to participate as a member of the team if requested by the individual • demonstrate understanding of Person Centered Planning • Medication Administration* * if required by the individual supported
--	--	--	---

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	FI	Prior to moving in
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Adult Companion	
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:		
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.	
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.	
<input type="radio"/>	Service is not included in the approved waiver.	
Service Definition (Scope):		
Non-medical care, supervision and socialization provided to an adult. Services may include assistance with meals and basic activities of daily living incidental to the support and supervision of the individual. This service is provided to carry out personal outcomes identified in the individual plan that supports an individual to successfully live in his/her own home. This service does not entail hands-on nursing care, except as permitted under the <i>Nurse Practice Act (CGS 20-101)</i> . This service is not available to participants who receive Continuous Residential Supports.		
Specify applicable (if any) limits on the amount, frequency, or duration of this service:		
May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Adult Day Health, Respite, Personal Support, or Residential Habilitation CTH.		
Provider Specifications		
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
	Individuals hired by participants who self direct	Private Providers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • Medication Administration* <p>* if required by the individual supported</p>
Private Providers			<p>The agency will ensure that employees meet the following qualifications :</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			sexual abuse, knowledge of approved and prohibited physical management techniques <ul style="list-style-type: none"> • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • Medication Administration* * if required by the individual supported
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individuals hired by participants who self direct	FI		Prior to Employment
	DDS		Annual sample of consumer-directed persons
Private Provider	DDS		Initial and every 2 years certification thereafter
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed

Service Title:	Clinical Behavioral Support Services (formerly Consultation)
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Clinical and therapeutic services which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. This service is available to individuals who have intellectual disabilities and demonstrate an emotional, behavioral or mental health issue that results in the functional impairment of the individual and substantially interferes with or limits functioning at home or in the community. Professional clinical service to include: 1) Assess and evaluate the behavioral and clinical need(s); 2) Develop a behavioral support plan that includes intervention techniques as well as teaching strategies for increasing new adaptive positive behaviors, and decreasing challenging behaviors addressing these needs in the individual's natural environments; 3) Provide training to the individual's family and the support providers in appropriate implementation of the behavioral support plan and associated documentation; and, 4) Evaluate the effectiveness of the behavioral support plan by monitoring the plan on a monthly basis, and by meeting with the team one month after the implementation of the behavior plan, and in future three month intervals. The service will include any changes to the plan when necessary and the professional(s) shall be available to the team for questions and consultation. The professional(s) shall make recommendations to the Individual Support Team and Case Manager for referrals to community physicians and other clinical professionals that support the recommendations of the assessment findings as appropriate. Use of this service requires the preparation of a formal comprehensive assessment and submission of any restrictive behavioral support program to the DDS Program Review Committee for approval prior to implementation.	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Specify applicable (if any) limits on the amount, frequency, or duration of this service:					
Provider Specifications					
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:	
	Psychologist				
	Behavior Specialist				
	Licensed Clinical Social Worker				
Specify whether the service may be provided by <i>(check each that applies):</i>		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>					
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>		
Psychologist	Licensed by the DPH and meets the qualifications in Connecticut General Statutes Chapter 383		All qualified providers --Criminal background check if requested by the participant. Registry check if requested by the participant. All qualified providers --Providers of this service to children must have 3 years of experience in working with children and adolescents with intellectual disabilities.		
Licensed Clinical Social Worker	Meets the qualifications in Connecticut General Statutes Chapter 383				
Behavior Specialist			Behavior Specialist Only -- Masters degree in psychology, special education, applied behavior analysis, or other related field and course work in human behavior. One year experience working with people with intellectual disabilities.		
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:		Frequency of Verification		
Individuals	DDS		Initially and annual licensing verification		
	DDS		Annual sample of consumer-directed persons		
Service Delivery Method					

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Service Title: Environmental Modifications				
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
<p>Those physical adaptations to the private residence of participant or the participant's family, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, accessibility modifications to bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, etc. Also excluded are those modifications which would normally be considered the responsibility of the landlord. Adaptations which add to the total square footage of the home are excluded from this benefit unless required for an accessibility accommodation. All services shall be provided in accordance with applicable State or local building codes. Home accessibility modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.</p>				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Maximum benefit over the term of the waiver (5 years) shall not exceed \$15,000. Copies of at least 3 bids must be submitted to the regional PRAT for review and approval for modifications that cost more than \$2500. Completion of work must be verified by DDS staff.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
	Private Contractors			
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License (specify)		Certificate (specify)	
Private Contractors	Licensed in State of CT		NFPA Life Safety Code State Building Code Proof of Insurance	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Private Contractors	FI		Initial	
Service Delivery Method				
Service Delivery Method	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

(check each that applies):				
----------------------------	--	--	--	--

Service Title:	Family Training			
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>				
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Provider Specifications				
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			DDS	
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
				Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
DDS who employs professionals in the following disciplines:			DDS will ensure that all staff providing Family Training qualify for their position as delineated in the Dept. of Administrative Services, Bureau of Human Resources Job Specifications (for DDS staff)	
Psychologist	Meets the requirements in Connecticut General Statutes Chapter 383		DDS will also conduct a Criminal background check and a Registry check prior to employing the individual.	
Special Ed Teachers	Meets the requirements in CGS Title 20 – Licensure			

State:	
Effective Date	

Appendix C: Participant Services
 HCBS Waiver Application Version 3.4

OT PT SP/L	Meets the requirements in CGS Chapter 368a Department of Public Health		
Registered Nurse	Must possess and retain a license as a Registered Professional Nurse in Connecticut.		
Dietician	Dietician/Nutrition Licensure per CGS Chapter 384b		
Behavior Specialist			Meets the requirements of the State of CT DAS Class Specification

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
DDS	DDS	Initial and Annual
Service Delivery Method		
Service Delivery Method (check each that applies):	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Health Care Coordination
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Assessment, education and assistance provided by a registered nurse to those waiver participants with identified health risks living in their own homes with less than 24 hour supports, who, as a result of their intellectual disability, have limited ability to identify changes in their health status or to manage their complex medical conditions. These participants have medical needs that require more healthcare coordination than is available through their primary healthcare providers to assure their health, safety and well-being. This service will ensure that there is communication between primary care physicians, medical specialists, and behavioral health practitioners, and will provide a resource person to communicate to consumers and direct support staff (if utilized by the participant) and train them to follow through on medical recommendations. The RN Healthcare Coordinator will complete a comprehensive nursing assessment on each participant and develop an integrated healthcare management plan for the participant and his/her support staff (if utilized by the participant) to	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

implement. This service shall provide the clinical and technical guidance necessary to support the participant in managing complex health care services and supports to improve health outcomes and prevent admission to a nursing facility. Support provided includes, but is not limited to, the following: train/retrain staff (if utilized by the participant) on interventions, monitor the effectiveness of interventions, coordinate specialists, evaluate treatment recommendations, review lab results, monitor, coordinate tests/results, and review diets. The RN Healthcare Coordinator does not provide skilled nursing services that are available under the Medicaid State plan. This service is only available to individuals with identified health risks who receive less than 24 hour supports in their own home. The RN Healthcare Coordinator does not provide skilled nursing services that are available under the Medicaid State plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
		RN		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
RN	Meets the qualifications in CGS Chapter 368a Department of Public Health		Criminal background check Registry check

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
RN	DDS	Initial and annual licensing verification.

Service Delivery Method

<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
-------------------------------------	---	-------------------------------------	------------------

Service Title:	Adult Day Health Services
-----------------------	----------------------------------

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.

Service Definition (Scope):

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structure, comprehensive program that provides a variety of health, social and related support services including, but not limited to, socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: the social model and the medical model. Both models shall include the minimum requirements described in Section 17b-342-2(b)(2) of the DSS regulations. In order to qualify as a medical model, adult day health services shall also meet the requirements described in Section 17b-342-2(b) (3) of the DSS regulations. May not be provided at the same time as Group Day, Supported Employment, Respite, Personal Support, Individualized Home Supports, Community Training Home or Continuous Residential Support.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

May not be provided at the same time as Group Day, Supported Employment, Senior Supports, Respite, Personal Support, Individualized Home Supports or Individualized Day Supports

Provider Specifications

Provider Category(s) (check one or both):	<input type="checkbox"/> Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		DSS Qualified Providers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
DSS Qualified Provider			<p>Provider must meet the requirements of Section 17b-342-2(b)(2) of the DSS regulations. Providers of the medical model of Adult Day Health must also meet the requirements of Section 17b-342-2(b)(3) of the DSS regulations. The agency will ensure that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>approved and prohibited physical management techniques</p> <ul style="list-style-type: none"> • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of Person Centered Planning • Medication Administration* <p>* if required by the individual supported</p>
--	--	--	---

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Private Agency	DSS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
--	--------------------------	---	-------------------------------------	------------------

Service Title: Individual Goods and Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- | | |
|----------------------------------|--|
| <input type="radio"/> | Service is included in approved waiver. There is no change in service specifications. |
| <input checked="" type="radio"/> | Service is included in approved waiver. The service specifications have been modified. |
| <input type="radio"/> | Service is not included in the approved waiver. |

Service Definition (Scope):

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes identified in the Individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home or in the community, be habilitative in nature and contribute to a therapeutic goal, enhance the individual's ability to be integrated into the community, or provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services. With Prior Approval this service may be used to pay a staff person to provide supervision to other direct hire employees. Experimental and prohibited treatments are excluded. With Prior Approval this service may be used to pay a staff person to provide supervision to other direct hire employees. This service is only available for individuals who self-direct his/her own supports, and must be pre-approved by DDS and follow DDS Cost Standards. DDS Cost Standards are a set of guidelines which are used to ensure applies consistent criteria with respect to the appropriateness of the services or items to be approved in this service definition and their cost. This service may not duplicate any Medicaid State Plan service. Direct supports under this service may not be provided at

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

the same time as Individualized Day Supports, Group Day, Supported Employment, Senior Supports, Respite, Personal Support, Individualized Home supports, Continuous Residential Supports, or Adult Companion.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Individuals hired by participants who self direct		Private Providers	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<ul style="list-style-type: none"> • demonstrate understanding of Person Centered Planning • Medication Administration* <p>* if required by the individual supported</p>
Private Agencies			<p>The agency will ensure that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of Person Centered Planning • Medication Administration* <p>* if required by the individual supported</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individual	FI		Prior to Employment
	DDS		Annual sample of consumer-directed persons
DDS Qualified	DDS		Initial and every 2 years

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Provider			certification thereafter
Service Delivery Method			
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/> Provider managed

Service Title:	Interpreter		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Service of an interpreter to provide accurate, effective and impartial communication where the waiver recipient or representative is deaf or hard of hearing or where the individual does not understand spoken English.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Individuals hired participants who self direct	Private or public translation agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired participants who self direct		Sign language interpreter: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired.	For any other language interpreter the FI will verify that the person meets the following qualifications: Prior to Employment <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • be proficient in both languages • be committed to confidentiality • understand cultural nuances and emblems • understands the interpreter's role to provide accurate interpretation
Private or public translation agencies		Certified to provide Interpreter Services	For any other language interpreter the agency will verify that the person meets the

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

		<p>by DDS</p> <p>Sign language interpreter:</p> <p>Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf.</p> <p>Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired.</p>	<p>following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • be proficient in both languages • be committed to confidentiality • understand cultural nuances and emblems • understands the interpreter's role to provide accurate interpretation
--	--	---	--

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired participants who self direct	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons
Private or public translation agencies	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
--	-------------------------------------	---	-------------------------------------	------------------

Service Title:	Nutrition (formerly Consultation)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Clinical assessment and development of special diets, positioning techniques for eating; recommendations for adaptive equipment for eating and counseling for dietary needs related to medical diagnosis for participants and training for paid support staff to ensure compliance with the participant's dietary needs. These services are not covered in the Medicaid State Plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
This service is limited to 25 hours of service per year.	
Provider Specifications	

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
	Dietician			
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Dietician	Dietitian/Nutrition Licensure per CGS Chapter 384b		Criminal background check Registry check	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Dietician	FI		Prior to Employment	
	DDS		Annual sample of consumer-directed persons	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Title:	Parenting Support
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input checked="" type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Parenting Support assists eligible consumers who are or will be parents in developing appropriate parenting skills. Individual training and support will be available. Parents will receive training that is individualized and focused on the health and welfare and developmental needs of their child. Close coordination will be maintained with informal supports and other formal supports. If the eligible consumer (parent) does not have physical custody or visitation rights, they will not receive individualized child-focused training.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Parenting Support is limited to an average of four hours of individualized child-focused direct training per week. Support is available from the first trimester until the eligible participant's child is 18 years of age.	
Provider Specifications	

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
				DDS Qualified Provider	
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):					
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)		
DDS Qualified Provider		Certified to provide Parenting Support by DDS	<ul style="list-style-type: none"> • Must be 21 years of age • Criminal background check • Abuse Registry check • Five years experience working with individuals with intellectual disabilities • College training in programs related to supporting people with disabilities (e.g. social service, education, psychology, or rehabilitation) may be substituted for experience on the basis of 15 semester hours equaling one-half year of experience to a maximum of 4 years. • Knowledge of relevant DDS and other State agency policies, procedures, and regulations • Knowledge of how to access generic community resources • Knowledge of Federal and State social services resources and assistance/benefit programs • Knowledge of all stages of child development • Knowledge of family dynamics/relationships • Knowledge of positive parenting skills • Knowledge of health/nutrition standards • Knowledge of home and community safety standards • Knowledge of relevant DDS and other State agency policies, procedures, and regulations 		

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p><i>Demonstrated ability, experience, education to:</i></p> <ul style="list-style-type: none"> teach adult learners conduct support needs assessments implement service/support plans assist parent in specific areas of support described in the plan serve as an advocate and effectively coordinate access to needed resources work with people of varied ethnic and cultural backgrounds
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
DDS Qualified Provider	DDS	Initial and every 2 years certification thereafter	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Personal Emergency Response System
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Private Vendor
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Private Vendor	Regulations of CT. State Agencies 17-134-165		Providers Shall: <ul style="list-style-type: none"> • Provide trained emergency response staff on a 24-hour basis • Have quality control of equipment • Provide service recipient instruction and training • Assure emergency power failure backup and other safety features • Conduct a monthly test of each system to assure proper operation • Recruit and train community-based responders in service provision Provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Private Vendor	DDS		Initial and every 2 years certification thereafter
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Senior Support
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input checked="" type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Senior Supports are provided for older clients, or clients who have needs that closely resemble those of an older	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

person, who desire a lifestyle consistent with that of the community's population of similar age or circumstances. This support is intended to facilitate independence and promote community inclusion as well as prevent isolation. Senior Supports consist of a variety of activities that are designed to assist the client in maintaining skills and stimulating social interactions with others. The activities are based on needs identified in the IP and may occur in any community setting, including the individual's place of residence.

May not be provided at the same time as Individualized Day Supports, Group Day, Supported Employment, Adult Day Health, Respite, Individualized Home Support, Adult Companion, or Continuous Residential Supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals hired by participants who self direct		Private Providers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<ul style="list-style-type: none"> Medication Administration* <p>* if required by the individual supported</p>
Private Providers			<p>The agency will ensure that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> 18 yrs of age criminal background check registry check have ability to communicate effectively with the individual/family have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan Medication Administration* <p>* if required by the individual supported</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired by participants who self direct	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons
Private Providers	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
--	--------------------------	---	--------------------------	------------------

Service Title:	Personal Support
-----------------------	-------------------------

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.			
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.			
<input type="radio"/>	Service is not included in the approved waiver.			
Service Definition (Scope):				
Assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. Provision of services is limited to the person's own or family home and/or in their community. This service differs from State Plan services in that participants can self-direct or can use DDS qualified providers rather than Home Health Agencies. May not be provided at the same time as Individualized Day Supports, Group Day, Supported Employment, Senior Supports, Adult Day Health, Respite, Individualized Home Support, Adult Companion, Continuous Residential Supports or Residential Habilitation CTH.				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
This service is not available to individuals living in residential settings providing Continuous Residential Support.				
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals hired by participants who self direct		Private Providers
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Individuals hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> 18 yrs of age criminal background check registry check have ability to communicate effectively with the individual/family have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and 	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques</p> <ul style="list-style-type: none"> • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • Medication Administration* <p>* if required by the individual supported</p>
Private Providers			<p>The agency will ensure that employees meet the following qualifications:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan • Medication Administration* <p>* if required by the individual supported</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individuals hired by participants who self direct	FI		Prior to Employment
	DDS		Annual sample of consumer-directed persons

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Private Providers	DDS	Initial and every 2 years certification thereafter
Service Delivery Method		
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Specialized Medical Equipment and Supplies		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.			
This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Prior approval will be required with documentation by a licensed therapy professional for single items costing more than \$750. The benefit package is limited to \$5,000 over the period of the waiver per recipient.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Vendors of Specialized Medical Equipment and Supplies
Specify whether the service may be provided by (check each that applies):		<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

Vendors of Specialized Medical Equipment and Supplies	Pharmacies: CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7.		Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8) Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91 Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Vendors of Specialized Medical Equipment and Supplies	DDS	Initial and every 2 years certification thereafter	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Title:	Independent Support Broker (replaces Family and Individual Consultation and Support)
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Support and Consultation provided to individuals and/or their families to assist them in directing their own plan of individual support. This service is limited to those who direct their own supports. The services included are: <ul style="list-style-type: none"> Assistance with developing a natural community support network Assistance with managing the Individual Budget Support with and training on how to hire and train staff Training on how to manage staff Accessing community activities and services, including helping the individual and family with the coordination of needed services. Assistance with negotiating rates and reimbursements. Developing an emergency back up plan Self advocacy training and support 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
This service is limited to those who direct their own supports.	

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
	Individual hired by participants who self direct		Private Providers
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individual hired by participants who self direct			<p>The FI will verify that employees meet the following qualifications:</p> <p>Prior to Employment:</p> <ul style="list-style-type: none"> • 21 yrs of age • criminal background check • registry check • demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan. • Five years experience in working with people with intellectual disabilities involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care. • One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation. <p>Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques</p> <ul style="list-style-type: none"> • demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services • demonstrate understanding of individual budgets and DDS fiscal management policies
Private Providers			<p>The agency cannot provide Individual Support Broker services to participants to whom they provide other waiver services.</p> <p>The agency will ensure that employees meet the following qualifications: Prior to Employment:</p> <ul style="list-style-type: none"> • 21 yrs of age • criminal background check • registry check • demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan. • Five years experience in working with people with intellectual disabilities involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care. • One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation. <p>Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General</p>

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

			<p>Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services • demonstrate understanding of individual budgets and DDS fiscal management policies
--	--	--	---

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired by the participant	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons
Private Providers	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
--	-------------------------------------	---	--------------------------	------------------

Service Title:	Transportation
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition	

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

- This service does not cover the purchase or lease of vehicles.
- Reimbursement for provider travel time is not included in this service.
- Reimbursement to the provider is limited to transportation that occurs when the individual is with the provider.
- The individual is not eligible for transportation services if the cost and responsibility for transportation is already included in the waiver provider's contract and payment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment per mile is made for a maximum of one round trip daily. Prior Approval must be obtained in order to utilize the per trip rate for a participant.

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Individuals hired by the participant		Private Providers	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals hired by the participant	CT Driver's License		<p>Individual Provider: Valid CT driver's license and insured vehicle.</p> <p>Verified by the FI:</p> <p>Prior to Employment</p> <ul style="list-style-type: none"> • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer <p>Prior to being alone with the Individual:</p> <ul style="list-style-type: none"> • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques

State:

Effective Date

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

Private Providers			<p>The agency will ensure that employees meet the following qualifications:</p> <ul style="list-style-type: none"> • Valid CT Driver's License • Proof of insurance if transporting in employees vehicle • 18 years of age • criminal background check • registry check • have ability to communicate effectively with the individual/family • have ability to complete record keeping as required by the employer • Prior to being alone with the Individual: • demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
-------------------	--	--	--

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals hired by participants who self direct	FI	Prior to Employment
	DDS	Annual sample of consumer-directed persons
Private Providers	DDS	Initial and every 2 years certification thereafter

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
--	--------------------------	---	--------------------------	------------------

Service Title:	Vehicle Modifications
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.

State:	
Effective Date	

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Alterations made to a vehicle which is the individual's primary means of transportation, when such modifications are necessary to improve the individual's independence and inclusion in the community, and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.</p> <p>The following are specifically excluded:</p> <ol style="list-style-type: none"> 1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; 2. Purchase or lease of a vehicle; and 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications. 			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The benefit package is limited to a maximum of \$10,000 during the waiver period per recipient for vehicle modifications. Once this cap is reached, \$750 per individual per year may be allowable for repair, replacement or additional modification with prior approval.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies: <div style="border: 1px solid black; padding: 2px;">Vendors who specialize in Vehicle Modifications</div>
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Vendors who specialize in Vehicle Modifications	Meets the qualifications in CGS 10-102-18(j) and has Dept. of Motor Vehicles Dealer's Registration		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
DDS Qualified Providers	DDS	Initial	
Service Delivery Method			
Service Delivery Method	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
			Provider managed

State:	
Effective Date	

Appendix C: Participant Services HCBS Waiver Application Version 3.4

(check each that applies):				
----------------------------	--	--	--	--

Appendix C-4: Additional Limits on Amount of Waiver Services
--

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

State:	
Effective Date	

Appendix C: Participant Services

HCBS Waiver Application Version 3.4

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

<input type="checkbox"/>	Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i>
<input checked="" type="checkbox"/>	Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i>

State:	
Effective Date	

The maximum amount of annualized funding available to individuals enrolled in this waiver for purchase of waiver goods and services is \$58,000 which is adjusted annually based on legislatively approved/mandated adjustments to the Department's allocation. Each individual receives a budget allocation based on the results of the participant's assessed Level of Need. The Level of Need is determined as a result of the completed CT Level of Need Assessment and Risk Screening Tool (LON). The resulting score of 0-8 is associated with a prospective individual funding amount for vocational related services and home and community services. The LON Assessment and preliminary associated funding levels were developed under the CMS Independence Plus Grant using qualitative and quantitative methodologies. The bulk of the historical financial data used to calculate these rates includes information on individuals who were served on Master Contracts prior to the conversion to the present Fee for Service model. The Department is continuing to analyze the historical funding data and refine the prospective allocation methodology from the present allocation method of categorizing people with an LON of 1 or 2 as Minimum with a allocation range up to \$27,300; those with an LON scores of 3 or 4 as Moderate with an allocation range up to \$60,100 and those with LON scores of 5, 6, and 7 as Comprehensive with an allocation range up to \$92,800 to an allocation amount based on more current use data. Individuals with scores of 8 have exceptional support needs and will receive an allocation based on their individual support needs. **People with an LON score of 0 will not be eligible to enroll in a waiver since they will not meet the Level of Care criteria.** People whose needs require a support package that exceeds \$58,000 are not enrolled in this waiver and are enrolled in the Comprehensive Waiver. During the period covered by this waiver the analysis of the data will continue and allocations will be modified according to the results of the analyses.

The **IFS Waiver** covers the following service packages and associated service limits defined by total cost for groups of waiver services and supports. IFS Waiver Service Packages and Limits: total amount of available services within each package is based first on the individual's assessed level of need, and, for any individual may not exceed without prior approval, the following suggested limits:

Home/Community Package to \$28,000	Day/Vocational Package to \$26,000	Ancillary Package to \$6,000	Other -require individual approvals
Individualized Home Supports	Group Day Options	Specialized Medical Equipment and Supplies	Environmental Modification
Continuous Residential Supports	Adult Day Health Services	Nutrition up to 25 hours per year	Individual Goods and Services
Personal Support	Individualized Day Supports	Clinical Behavioral Support	Vehicle Modifications
Community Training Home	Supported Employment	Interpreter Services	Family Training
Adult Companion	Senior Supports	Transportation	Health Care Coordination
Respite			Parenting Support
Live-In Companion			
PERS			

The DDS Regional Planning and Resource Allocation Team notify the applicant of the funding limit via letter as described in Appendix D. The LON based budget allocation limits apply to all services with the exception of Specialized Adaptive Equipment, Vehicle Modification and Environmental Modifications, which are not annualized services. Adjustments to the budget allocation limit can be made either as a result of a higher assessed Level of Need leading to an increased LON score, or due to short-term circumstances necessitating an increased amount of services to address short term health and safety needs. If the need for services required to address health and safety needs appears to be long-term and the cost to provide those services exceed the overall limit of the IFS waiver, the participant will be referred for enrollment in the DDS Comprehensive waiver. The state applies any legislatively approved/mandated adjustments to these dollar amounts each year the waiver is in effect.

Appendix C: Participant Services
HCBS Waiver Application Version 3.4

<input type="checkbox"/>	Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
<input type="checkbox"/>	Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

State:	
Effective Date	

Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

<input checked="" type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The CT Department of Developmental Services (DDS) will provide consumer-directed options for participants who choose to direct the development of their Individual Plans and to have choice and control over the selection and management of waiver services. Individuals may choose to have either employer authority or budget authority or both.

The Individual Planning process is designed to promote and encourage the individual and those people who know and care about him or her to take the lead in directing the process and in planning, choosing, and managing supports and services to the extent they desire. The development of the Individual Plan is participant led. During the planning process services and supports are identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. At the time of the planning process, the individual's case manager ensures the person and his or her family or personal representative have sufficient information available to make informed choices about the degree to which they wish to self-direct supports and services. The case manager also ensures the individual and his or her family or personal representative have information to make informed selections of qualified waiver providers. This information is presented in three Consumer Guidebooks: Understanding the HCBS waivers; Your Hiring Choices; and Making Good Choices about your DDS Supports and Services. Case managers also notify individuals about their ability to change providers when they are not satisfied with a provider's performance.

Self-direction is included in the Individual and Family Support Waiver to the extent the individual

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

and/or family wishes to directly manage services and supports. Individuals may self-direct some or all of their waiver services identified in the Individual Plan. They may choose to self-direct workers and professionals who provide the following services: Individualized Home Support, Personal Support, Adult Companion Services, Continuous Residential Support (Agency with Choice only), Respite, Supported Employment Services, Individualized Day Support, Senior Supports, Transportation, Clinical Behavioral Support Services, Live-in Companion, Individual Goods and Services, Nutrition, Independent Support Broker, and Interpreter Services. In addition, participants have Budget Authority over the following services: Environmental Modifications, Vehicle Modifications, and Special Medical Equipment and Supplies.

Individuals who self-direct may choose to be the direct employer of the workers who provide waiver services, or may select an Agency with Choice. The Agency with Choice is the employer of record for employees hired to provide waiver services for the individual, however the individual maintains the ability to select and supervise those workers. The individual may refer staff to the Agency with Choice for employment. In both arrangements, the individual and/or family have responsibility for managing the services they choose to direct.

Individuals who self-direct and hire their own workers have the authority to recruit and hire staff, verify staff qualifications, obtain and review criminal background checks, determine staff duties, set staff wages and benefits within established guidelines, schedule staff, provide training and supervision, approve time sheets, evaluate staff performance, and terminate staff employment.

Individuals who self direct by hiring their own staff will have a DDS case manager or, a specialized case manager (Support Broker), to assist them to direct their plan of individual support. In addition to case management activities, the Support Brokers assist individuals to access community and natural supports and advocate for the development of new community supports as needed. They assist individuals to monitor and manage the Individual Budgets. Brokers may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist individuals to develop an emergency backup plan and may assist individuals to access self-advocacy training and support.

Another option for those who self-direct is to have a DDS case manager and an Independent Support Broker through the waiver service. This waiver service provides support and consultation to individuals and/or their families to assist them in directing their own plan of individual support. This service may be self-directed or provided by a qualified agency and is available to those who direct their own supports and hire their own staff. The services included in Independent Support Broker service are:

- Assistance with developing a natural community support network
- Assistance with managing the Individual Budget
- Support with and training on how to hire and train staff
- Training on how to manage staff
- Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services.
- Developing an emergency backup plan
- Self advocacy training and support

The services of a Fiscal Intermediary (FI) are required for individuals who self-direct their services and supports. The FI assists the individual and/or family or personal representative to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

withholding/payments, processing payroll or making payments for goods and services and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, support to enter into provider agreements on behalf of the Medicaid agency, and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their Individual Plan. The service will be delivered as an administrative cost and is not included in individual budgets.

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant’s representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

- d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input checked="" type="radio"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

State:	
Effective Date	

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager provides information about options to self-direct to the participants and their families at the time of the Individual Planning meeting and at any time the individual expresses an interest in self-direction. (This includes a Family Manual on Self-Direction and Your Hiring Choices <http://www.dmr.state.ct.us/HCBS/DMRbook2ENG.pdf>, and informational fact sheets).

The Fiscal Intermediary has responsibility to provide fact sheets to individuals who are referred to them who choose to self-direct. Fact sheets include information about criminal background checks, abuse/neglect registry checks, employer responsibilities, hiring and managing your own supports, employee safety: workers compensation and liability insurance. The Fiscal Intermediary ensures that individual provider qualifications and training requirements are met prior to employment and the appropriate forms to document that training are completed.

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input checked="" type="checkbox"/>	<p>Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:</p> <p>The state's practice is to allow participants the opportunity to self direct waiver services with the assistance they need by allowing family members, advocates, or a representative of the participant's choosing, to assist with the responsibilities of self-direction. A representative does not have to be a legal representative. The representative assumes responsibilities for the Agreement For Self Directed Supports, which is reviewed with the representative and the participant, and signs the Agreement. The participant can also be the sponsoring person. The Agreement for Self Directed Supports includes the identification of areas of responsibility where the responsible person will require assistance. Any assistance needed as indicated in the agreement must be addressed in the participant's Individual Plan.</p>

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Waiver Service	Employer Authority	Budget Authority
-------------------------------------	--------------------	------------------

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

Individualized Home Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Companion	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Continuous Residential Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individualized Day Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Clinical Behavioral Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Interpreter	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Independent Support Broker	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Nutrition	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Senior Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Live-in Caregiver	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Modifications	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

<input type="radio"/>	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3.
<input checked="" type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
i.	<p>Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:</p> <p>Fiscal Intermediaries are procured through a competitive RFP process. Private not for profit and for profit corporations and LLC's furnishing these services. CT DDS pays the Fiscal Intermediaries directly per the contract. Participants who self direct must use a Fiscal Intermediaries under contract with the state. CT requires the re-bidding of Fiscal Intermediary contracts every three years.</p>

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:	
	Payment through a contract with the DDS as a result of an awarded RFP.	
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>):	
	<i>Supports furnished when the participant is the employer of direct support workers:</i>	
	<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status
	<input checked="" type="checkbox"/>	Collect and process timesheets of support workers
	<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	<input checked="" type="checkbox"/>	Other (<i>specify</i>):
		Verify training requirements of direct support workers are completed.
	<i>Supports furnished when the participant exercises budget authority:</i>	
	<input checked="" type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
	<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
	<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
	<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	<input type="checkbox"/>	Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>	
<input checked="" type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency	
<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	
<input checked="" type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget	
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

		<p>Fiscal Intermediaries provide an enrollment packet to each individual to whom it provides services under their state contract. The enrollment packet includes the State's forms and information (employee application, fact sheet on employer liability and safety, Criminal Background and Abuse/Neglect Registry checks, Individual Provider Medicaid agreement, employee and Vendor Agreement forms, Individual Provider Training Verification Record and training materials).</p> <p>Fiscal Intermediaries meet with each participant who is hiring individual providers to review all of the State and Federal employer requirements.</p> <p>Fiscal Intermediaries secure Workers Compensation Policies for each participant employer with employees who work 26 or more hours per week and for employers and employees who choose to have Worker's Compensation Insurance for employees who work fewer than 26 hours per week. The Contractor is responsible for filing Criminal History Background Check, Abuse/Neglect Registry Check, driver's license checks, Workers Compensation Policies, and training verification records along with all state and federal employee and employer forms.</p>
	iv.	<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p>
		<p>The state conducts an annual performance review of Fiscal Intermediaries. Fiscal Intermediaries are responsible for providing the state with an independent annual audit of its organization and the state funds and expenditures under the agent's control according to procedures dictated by the CT DDS audit unit (Fiscal Intermediaries contract template Part 3). In addition, quarterly statements of expenditures against individual budgets are sent to the individual and the regional office. These statements are reviewed on a periodic basis by regional administration staff and the individual's case manager, DDS support broker or the Independent Support Broker. In addition to the quarterly statements an annual expenditure report is submitted for each participant that is reviewed by the state and either accepted or sent back for clarification or changes.</p>

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input checked="" type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p> <p>The role of the DDS case manager (TCM) in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. Case managers support individuals to be actively involved in the planning process. Case managers share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. Case managers assist the person to develop an individual budget and assist with arranging supports and services as described in the plan. They also assist the individual to monitor services and make changes as needed. Case managers share information regarding the ability to change providers when individuals are dissatisfied with performance.</p> <p>As described in Section E.1.a, individuals who self direct by hiring their own staff will have case manager <u>or</u> a specialized case manager, called a DDS support broker, to assist them to direct their plan of individual support. In addition to case management (TCM) activities, the DDS Support Brokers provide individuals support with and training on how to hire, train and manage the staff, negotiate provider rates, develop and manage the individual budget, develop emergency back up plans, and provide support and training to access and develop self-advocacy skills. These additional duties are considered outside the scope of the TCM service so the time/costs are not included in the rate setting methodology for TCM.</p>
<input checked="" type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage(s) specified in Appendix C-3 entitled: Independent Support Broker</p>
<input type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

- k. Independent Advocacy** (*select one*).

<input checked="" type="radio"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>Independent Advocacy is available to participants through the Office of the Ombudsperson for Developmental Services as well as through the use of an Independent Support Broker.</p>
<input type="radio"/>	<p>No. Arrangements have not been made for independent advocacy.</p>

State:	
Effective Date	

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Individuals may through the Individual Plan process request the termination of self-direction and his or her Self Directed Support Agreement and Individualized Budgets.

An individual/family may decide to terminate the Self Directed Support Agreement and Individualized budget and choose an alternative support service. The case manager, support broker or regional designee discusses with the individual/family all the available options and resources available, updates the individual plan, and begins the process of referral to those options. Once the new option has been identified and secured, the case manager, support broker or regional designee will fill out the form for termination of the individual budget. The form is sent within 10 business days to the Fiscal Intermediaries, Resource Administrator, or regional designee, and the regional fiscal office representative.

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each individual who self-directs by hiring his or her own workers has an Agreement for Self Directed Supports describing the expectations of participation. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports: Key terms are:

1. To participate in the development and implementation of the Individual Planning Process.
2. Funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipient's individual plan and authorized individual budget.
3. To actively participate in the selection and ongoing monitoring of supports and services
4. To understand that no one can be both a paid employee and the employer of record.
5. To authorize payments for services provided only to the recipient according to the individual plan and budget.
6. To enter into an agreement with the provider agency/agencies or individual support worker(s) hired. The agreement is outlined in the Individual Family Agreements with Vendors and Employees and identifies the type and amount of supports and services that will be provided.
7. To submit timesheets, receipts, invoices, expenditure reports, or other documentation on the required forms on a monthly basis or within the agreed upon timeframe.
8. To review the expenditures reports on a quarterly basis and notify the case manager, broker and Fiscal Intermediaries of any questions or changes.
9. To follow the DDS Cost Standards and Costs Guidelines for all services and supports purchased with the DDS allocation.
10. To get prior authorization from the DDS to purchase supports, services, or goods from a party that is related to the individual through family, marriage, or business association.
11. To seek and negotiate reasonable fees for services and reasonable costs for items, goods, or equipment, and to obtain three bids for purchases of items, equipment, or home modifications over \$2,500.
12. Any special equipment, furnishings, or items purchased under the agreement are the property of the service recipient and will be transferred to the individual's new place of residence or day program or be returned to the state when the item is no longer needed..

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

13. To participate in the department's quality review process.
14. To use qualified vendors enrolled by DDS.
15. To ensure that each employee has read the required training materials and completed any individual specific training in the Individual Plan prior to working with the person.
16. To offer employment to any new employee on a conditional basis until the Criminal History Background Check, Driver's License Check, and DDS Abuse Registry Check has been completed. Anyone on the DDS Abuse Registry cannot be employed to provide support to the individual.
17. To notify the case manager/broker when the individual is no longer able to meet the responsibilities for self directed services.

The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing-services.

An Agreement for Self-Directed Supports can be terminated if the participant does not comply with the agreed upon requirements. The DDS case manager would coordinate the transition of services and assist the individual to choose a qualified provider to replace the directly hired staff.

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		400
Year 2		440
Year 3		480
Year 4 (renewal only)		1000
Year 5 (renewal only)		1100

State:	
Effective Date	

Appendix E-2: Opportunities for Participant-Direction

a. **Participant – Employer Authority** (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. Check each that applies:

■	<p>Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:</i></p> <p>Agencies with Choice are permitted and encouraged. Any DDS Qualified Provider may apply to be categorized as an "Agency with Choice". DDS requires specific assurances to enroll and be designated as an Agency with Choice organization through the submission of policies and procedures that support the control and oversight by the participants over the employees, and requires periodic participation in DDS sponsored training and events in consumer-direction.</p>
■	<p>Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

■	Recruit staff
■	Refer staff to agency for hiring (co-employer)
■	Select staff from worker registry
■	Hire staff (common law employer)
■	Verify staff qualifications
■	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Costs are covered in the individual budget provided for the participant by DDS.
■	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
■	Determine staff duties consistent with the service specifications in Appendix C-3.
■	Determine staff wages and benefits subject to applicable State limits
■	Schedule staff
■	Orient and instruct-staff in duties
■	Supervise staff
■	Evaluate staff performance

State:	
Effective Date	

Appendix E: Participant Direction of Services

HCBS Waiver Application Version 3.4

<input type="checkbox"/>	Verify time worked by staff and approve time sheets
<input type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (<i>specify</i>):

b. Participant – Budget Authority (*Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b*)

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input type="checkbox"/>	Reallocate funds among services included in the budget
<input type="checkbox"/>	Determine the amount paid for services within the State's established limits
<input type="checkbox"/>	Substitute service providers
<input type="checkbox"/>	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
<input type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Initial funding range provided by the Regional Planning and Resource Allocation Team based on Level of Need Assessment. Within that allocation individuals design an Individual Budget to support the outcomes identified in the Individual Plan. The resource allocation ranges derived from analysis of past utilization and costs for services used by like individuals based on assessed level of need as described in Appendix B of this application. The participant can direct the entire budget for waiver goods and services as the participant chooses. Information regarding this process is available to the public on the DDS website and in the "Guide for Consumers and their Families".

State:	
Effective Date	

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Regional Planning and Resource Allocation Team (PRAT) provides the individual with the resource allocation based on their assessed Level of Need in writing. Following the development of the Individual Plan, the individual may request additional funding based on identified needs. The request is reviewed by the regional PRAT, or may go to a regional or state level utilization review process depending upon the amount of funding requested beyond the initial funding range. Any denial of service/funding levels is communicated in writing by the Central Office Waiver Policy Unit and includes the formal notice and requests for a Fair Hearing. This same process applies any time an individual requests an increase in approved funding levels.

State:	
Effective Date	

iv. **Participant Exercise of Budget Flexibility.** *Select one:*

●	<p>The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:</p> <p><u>Adjustments are changes to existing Individual Budgets in amount or type of waiver service without a change in funding:</u></p> <p>The individual/family and case manager or support broker discuss the need for a change in the type or amount of a particular support or service that does not increase the total budget. When this change is within existing line items or results in a new line item without a change in the authorized allocation, a revision to individual the individual budget is required to effect the change. Individuals who are self-directing and have an Individual Budgets may shift funds among waiver services authorized in their budgets up to the designated amount identified in policy without a change in the Individual Plan. When changes exceed the designated amount found in policy or include a new waiver service a change in the Individual Plan is required. The case manager reviews the proposed changes with the Planning and Service Team. When the Planning and Service Team is in agreement with the changes, the case manager has the option of updating the IP and all relative sections, completing an IP 12, Periodic Review Form, or developing a new plan. An IP 6 and a Waiver Form 223 are required and the case manager supervisor is required to authorize the change..</p> <p>.</p>
○	<p>Modifications to the participant-directed budget must be preceded by a change in the service plan.</p>

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

<p>The FI monitors expenditures and alerts the waiver participant and Department's support broker/case manger of any variance in line items prior to payment that exceed the quarterly budgeted amount for the specific line item where the variance occurred.</p> <p>The FI has a system to verify that the service or support or product billed is in the authorized Individual Budget prior to making payment. The FI is responsible to cover out of its' own funds any payments that exceed what the state has authorized in the Individual Budget.</p> <p><u>Monthly and Quarterly Utilizations Reports:</u></p> <p>Each region has a regional contact person to whom the FI sends the <u>Quarterly Utilizations Reports</u>. Each region has an internal system for distribution and review of these reports. In addition to the quarterly expenditure report the participant and the case manager also receive a monthly expenditure report. The reports are due the 25th day of the following month. The DDS case manager/broker monitors the monthly expenditure reports, and is responsible to review the expenditure reports against the approved individual plan and budget on at least a quarterly basis to monitor for under/over utilization. The region administrator reviews the quarterly reports for utilization and follows up with the case manager/broker when there are significant gaps in service.</p>
--

State:	
Effective Date	

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	\$17,156	\$7,084	\$24,240	\$190,960	\$5,923	\$196,883	\$172,643
2	\$19,113	\$7,297	\$26,410	\$196,689	\$6,101	\$202,790	\$176,380
3	\$19,592	\$7,515	\$27,107	\$202,589	\$6,284	\$208,873	\$181,766
4	\$24,086	\$7,741	\$31,827	\$208,667	\$6,472	\$215,139	\$183,312
5	\$24,980	\$7,973	\$32,953	\$214,927	\$6,666	\$221,593	\$188,640

State:	
Effective Date	

Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	4018		
Year 2	4468		
Year 3	4468		
Year 4 (renewal only)	4100		
Year 5 (renewal only)	4150		

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The average length of stay was calculated by taking the average length of stay for those enrolled in the waiver from 2/1/06 through 1/31/07. The last full year for which we have data. This yielded an average length of stay of 352 days.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates of Factor D are based on past utilization of services prorated for estimates of increased enrollment.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was based on the third year of the Comprehensive Waiver as the W-372 report for the first year of the IFS waiver was low due to the large number of people who were enrolled in the last four months of the first year. The effects of Medicare D were not factored in.

State:	
Effective Date	

State:	
Effective Date	

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was based on the W-372 report for the first year of the IFS waiver.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was based on the W-372 report for the first year of the IFS waiver

State:	
Effective Date	

d. **Estimate of Factor D.** *Select one:* Note: Selection below is new.

<input checked="" type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. **Estimate of Factor D – Non-Concurrent Waiver.** Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Individualized Home Supports (replaces SL and IS Hab)	Per 15 min	689	1080	\$6.20	\$4,613,544.00
Residential Habilitation CTH	Per Diem	40	352	\$71.00	\$999,680.00
Adult Day Health Services	Per Diem	25	225	\$75.00	\$421,875.00
Personal Support	Per 15 min	363	1500	\$4.50	\$2,450,250.00
Adult Companion Service	Per 15 min	31	295	\$2.75	\$25,148.75
Respite less than 24 hours	Per 15 min	43	112	\$3.00	\$14,448.00
Respite over night	Per Diem	59	9	\$140.00	\$74,340.00
Supp Emp - Individual	Per 15 min	662	1409	\$12.26	\$11,435,613.08
Supp Emp - Group	Per Diem	1409	225	\$78.00	\$24,727,950.00
Group Day Supports	Per Diem	1001	225	\$78.00	\$17,567,550.00
Individualized Day Supports	Per 15 min	307	3520	\$5.00	\$5,403,200.00
Family Training	Per Hour	150	4	\$60.00	\$36,000.00
Live In Care Giver	Per Month	5	12	\$500.00	\$30,000.00
Environmental Modifications	Per Service	5	1	\$8,000.00	\$40,000.00
Vehicle Mods	Per Service	3	1	\$7,500.00	\$22,500.00
Transportation	Per mile	261	1778	\$0.40	\$185,623.20
Transportation - trip	Per Trip	44	153	\$28.00	\$188,496.00
Specialized Medical Equipment & Supplies	Per Service	25	1	\$750.00	\$18,750.00
Pers Emergency Response	Per Month	8	12	\$58.00	\$5,568.00
Clinical Behavioral Support Services	Per 15 min	61	450	\$16.25	\$446,062.50
Nutrition	Per 15 min	12	8	\$16.25	\$1,560.00
Health Care Coordination	Per 15 min	56	177	\$16.74	\$161,070.00
Interpreter Service	Per 15 min	25	96	\$16.25	\$39,000.00
Individual Directed Goods & Services	Per Service	10	6	\$100.00	\$6,000.00
Independent Support Broker	Per 15 min	6	250	\$12.50	\$18,750.00
GRAND TOTAL:					\$68,932,978.53
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4018
FACTOR D (Divide grand total by number of participants)					\$17,156.04
AVERAGE LENGTH OF STAY ON THE WAIVER					352

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Individualized Home Supports (replaces SL and IS Hab)	Per 15 min	1700	1080	\$6.39	\$11,732,040.00
Residential Habilitation CTH	Per Diem	43	352	\$73.13	\$1,106,895.68
Adult Day Health Services	Per Diem	30	225	\$77.25	\$521,437.50
Personal Support	Per 15 min	404	1500	\$4.64	\$2,811,840.00
Adult Companion Service	Per 15 min	34	295	\$2.83	\$28,384.90
Respite less than 24 hours	Per 15 min	48	112	\$3.09	\$16,611.84
Respite over night	Per Diem	66	9	\$144.20	\$85,654.80
Supp Emp - Individual	Per 15 min	736	1409	\$12.63	\$13,097,613.12
Supp Emp - Group	Per Diem	1566	225	\$80.34	\$28,307,799.00
Group Day Supports	Per Diem	1114	225	\$80.34	\$20,137,221.00
Individualized Day Supports	Per 15 min	342	3520	\$5.15	\$6,199,776.00
Family Training	Per Hour	150	4	\$61.80	\$37,080.00
Live In Care Giver	Per Month	12	12	\$500.00	\$73,980.00
Environmental Modifications	Per Service	5	1	\$8,240.00	\$41,200.00
Vehicle Mods	Per Service	3	1	\$7,500.00	\$22,500.00
Transportation	Per mile	290	1778	\$0.41	\$211,404.20
Transportation - trip	Per Trip	49	153	\$28.84	\$216,213.48
Specialized Medical Equipment & Supplies	Per Service	25	1	\$750.00	\$19,312.50
Pers Emergency Response	Per Month	8	12	\$59.74	\$5,735.04
Clinical Behavioral Support Services	Per 15 min	62	450	\$16.74	\$467,046.00
Nutrition	Per 15 min	12	8	\$16.74	\$1,607.04
Health Care Coordination	Per 15 min	63	177	\$16.74	\$186,667.74
Interpreter Service	Per 15 min	25	96	\$16.74	\$40,176.00
Individual Directed Goods & Services	Per Service	15	6	\$100.00	\$9,000.00
Independent Support Broker	Per 15 min	6	250	\$12.50	\$18,750.00
GRAND TOTAL:					\$85,395,945.84
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4468
FACTOR D (Divide grand total by number of participants)					\$19,112.79
AVERAGE LENGTH OF STAY ON THE WAIVER					352

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Individualized Home Supports (replaces SL and IS Hab)	Per 15 min	1709	1080	\$6.58	\$12,144,837.60
Residential Habilitation CTH	Per Diem	42	352	\$75.32	\$1,113,530.88
Adult Day Health Services	Per Diem	32	225	\$79.57	\$572,904.00
Personal Support	Per 15 min	404	1500	\$4.77	\$2,890,620.00
Adult Companion Service	Per 15 min	34	295	\$2.92	\$29,287.60
Respite less than 24 hours	Per 15 min	48	112	\$3.18	\$17,095.68
Respite over night	Per Diem	66	9	\$148.53	\$88,226.82
Supp Emp - Individual	Per 15 min	736	1409	\$13.01	\$13,491,682.24
Supp Emp - Group	Per Diem	1566	225	\$82.75	\$29,156,962.50
Group Day Supports	Per Diem	1088	225	\$82.75	\$20,257,200.00
Individualized Day Supports	Per 15 min	342	3520	\$5.30	\$6,380,352.00
Family Training	Per Hour	139	4	\$63.65	\$35,389.40
Live In Care Giver	Per Month	14	12	\$530.45	\$89,115.60
Environmental Modifications	Per Service	6	1	\$8,487.20	\$50,923.20
Vehicle Mods	Per Service	3	1	\$7,956.75	\$23,870.25
Transportation	Per mile	290	1778	\$0.42	\$216,560.40
Transportation - trip	Per Trip	49	153	\$29.71	\$222,735.87
Specialized Medical Equipment & Supplies	Per Service	23	1	\$795.68	\$18,300.64
Pers Emergency Response	Per Month	9	12	\$61.53	\$6,645.24
Clinical Behavioral Support Services	Per 15 min	58	450	\$17.24	\$449,964.00
Nutrition	Per 15 min	11	8	\$17.24	\$1,517.12
Health Care Coordination	Per 15 min	63	177	\$17.24	\$192,243.24
Interpreter Service	Per 15 min	23	96	\$17.24	\$38,065.92
Individual Directed Goods & Services	Per Service	18	6	\$106.09	\$11,457.72
Independent Support Broker	Per 15 min	11	250	\$13.26	\$36,465.00
GRAND TOTAL:					\$87,535,952.92
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4468
FACTOR D (Divide grand total by number of participants)					\$19,591.75
AVERAGE LENGTH OF STAY ON THE WAIVER					352

State:	
Effective Date	

Waiver Year: Year 4 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health	Per Diem	10	100	\$63.73	\$63,730.00
Adult Day Health-Medical	Per Diem	0	0	\$67.88	
Adult Day Health-Half Day	Per Diem	0	0	\$41.55	
Community Training Homes	Per Diem	20	352	\$77.58	\$546,163.20
Group Day Supports-Current Provider Rate	Per 15 minutes	895	3900	\$4.09	\$14,276,145.00
Live-In Companion	Per month	15	12	\$515.00	\$92,700.00
Group Respite Per Diem—Agency-Rate 1	Per Diem	0	0	\$130.60	
Group Respite Per Diem—Agency-Rate 2	Per Diem	190	16	\$165.90	\$504,336.00
Group Respite Per Diem—Agency-Rate 3	Per Diem	21	16	\$224.63	\$75,475.68
Group Respite Per 15 minutes—Agency-Rate 1	Per 15 minutes			\$2.43	
Group Respite Per 15 minutes —Agency-Rate 2	Per 15 minutes			\$3.16	
Group Respite Per 15 minutes —Agency-Rate 3	Per 15 minutes			\$4.39	
Individual In Home Respite Per Diem-Agency	Per Diem			\$308.04	
Individual In Home Respite Per 15 minutes-Agency	Per 15 minutes			\$6.42	
Individual Out of Home Respite Per Diem-Agency	Per Diem			\$335.97	
Individual Out of Home Respite Per 15 minutes-Agency	Per 15 minutes	400	1450	\$6.71	\$3,891,800.00
Two Person In Home Respite Per Diem-Agency	Per Diem			\$192.53	
Two Person In Home Respite Per 15 minutes-Agency	Per 15 minutes			\$4.02	
Two Person Out of Home Respite Per Diem-Agency	Per Diem			\$220.45	
Two Person Out of Home Respite Per 15 minutes-Agency	Per 15 minutes			\$4.31	
Individual In Home Respite Per Diem-Direct Hire	Per Diem			\$214.80	
In Home Respite Per 15 minutes-Direct Hire	Per 15 minutes			\$4.38	
Individual Out of Home Respite Per Diem-Direct Hire	Per Diem			\$252.30	
Two Person In Home Respite Per Diem-Direct Hire	Per Diem			\$161.10	
Two Person Out of Home Respite Per Diem-Direct Hire	Per Diem			\$188.91	
Individual Supported Employment	Per 15 minutes	300	1400	\$14.97	\$6,287,400.00
Group Supported Employment -Current Provider Rate	Per 15 minutes	1470	4000	\$2.81	\$16,522,800.00
Group Supported Employment -Current Provider Rate with Benefits	Per 15 minutes			\$2.94	
Independent Support Broker	Per 15 minutes	12	250	\$12.88	\$38,640.00
Adult Companion--Agency	Per 15 minutes	40	1600	\$4.36	\$279,040.00
Adult Companion-Direct Hire	Per 15 minutes	15	1600	\$3.16	\$75,840.00

State:	
Effective Date	

Waiver Year: Year 4 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Clinical Behavioral Support Services	Per 15 minutes	176	200	\$30.90	\$1,087,670.00
Continuous Residential Supports	Per Diem	3	176	\$282.00	\$148,896.00
Environmental Modifications	Per Service	6	1	\$8240.00	\$49,440.00
Family Training	Per 15 minutes	110	80	\$16.39	\$144,232.00
Health Care Coordination	Per 15 minutes	68	177	\$18.28	\$220,018.08
Individual Goods and Services	Per Service	4	8	\$103.00	\$3,296.00
Individualized Day Supports-Agency	Per 15 minutes	300	1350	\$8.29	\$3,357,450.00
Individualized Day Supports-Direct Hire	Per 15 minutes	88	1350	\$5.76	\$684,288.00
Individualized Home Supports-Agency	Per 15 minutes	1000	4800	\$8.29	\$39,792,000.00
Individualized Home Supports-Direct Hire	Per 15 minutes	104	2080	\$5.76	\$1,246,003.20
Interpreter-Current Provider Rate	Per 15 minutes	6	500	\$14.16	\$42,480.00
Interpreter-Language	Per 15 minutes	0	0	\$19.31	
Interpreter-American Sign Language	Per 15 minutes	0	0	\$11.85	
Nutrition	Per 15 minutes	12	16	\$18.28	\$3,509.76
Parenting Support	Per 15 minutes	25	400	\$12.88	\$128,800.00
Personal Emergency Response System-Installation	Per Unit	4	1	\$36.78	\$147.12
Personal Emergency Response System-Ongoing Monitoring-One Way	Per Month	0	0	\$30.65	
Personal Emergency Response System-Ongoing Monitoring-Two Way	Per Month	19	12	\$61.28	\$13,971.84
Personal Support-Agency	Per 15 minutes	650	1600	\$6.50	\$6,760,000.00
Personal Support-Direct Hire	Per 15 minutes	75	1600	\$5.76	\$691,200.00
Senior Supports-Agency	Per 15 minutes	5	2700	\$5.66	\$76,410.00
Senior Supports-Direct Hire	Per 15 minutes	2	1872	\$5.66	\$21,191.04
Specialized Medical Equipment and Supplies	Per Service	3	5	\$772.50	\$11,587.50
Transportation-Agency	Per Mile	685	1600	\$0.89	\$975,440.00
Transportation-Agency	Per Trip	75	200	\$30.60	\$459,000.00
Transportation-Wheelchair	Per Mile	6	1600	\$1.75	\$16,800.00
Transportation-Direct Hire	Per Mile	200	1600	\$0.44	\$140,800.00
Vehicle Modifications	Per Service	3	1	\$7725.00	\$23,175.00
GRAND TOTAL:					\$98,751,875.42
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4100
FACTOR D (Divide grand total by number of participants)					\$24,085.82

State:	
Effective Date	

Waiver Year: Year 4 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
AVERAGE LENGTH OF STAY ON THE WAIVER					352

Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health	Per Diem	10	100	\$65.32	\$65,320.00
Adult Day Health-Medical	Per Diem	0	0	\$69.58	
Adult Day Health-Half Day	Per Diem	0	0	\$42.59	
Community Training Homes	Per Diem	20	352	\$79.91	\$562,566.40
Group Day Supports-Current Provider Rate	Per 15 minutes	900	3900	\$4.21	\$14,777,100.00
Live-In Companion	Per month	15	12	\$530.45	\$95,481.00
Group Respite Per Diem—Agency-Rate 1	Per Diem	0	0	\$134.52	
Group Respite Per Diem—Agency-Rate 2	Per Diem	195	16	\$170.88	\$533,145.60
Group Respite Per Diem—Agency-Rate 3	Per Diem	21	16	\$231.37	\$77,740.32
Group Respite Per 15 minutes—Agency-Rate 1	Per 15 minutes			\$2.50	
Group Respite Per 15 minutes —Agency-Rate 2	Per 15 minutes			\$3.25	
Group Respite Per 15 minutes —Agency-Rate 3	Per 15 minutes			\$4.25	
Individual In Home Respite Per Diem-Agency	Per Diem			\$317.28	
Individual In Home Respite Per 15 minutes-Agency	Per 15 minutes			\$6.61	
Individual Out of Home Respite Per Diem-Agency	Per Diem			\$346.05	
Individual Out of Home Respite Per 15 minutes-Agency	Per 15 minutes	405	1450	\$6.91	\$3,940,447.50
Two Person In Home Respite Per Diem-Agency	Per Diem			\$198.31	
Two Person In Home Respite Per 15 minutes-Agency	Per 15 minutes			\$4.14	
Two Person Out of Home Respite Per Diem-Agency	Per Diem			\$227.06	
Two Person Out of Home Respite Per 15 minutes-Agency	Per 15 minutes			\$4.44	
Individual In Home Respite Per Diem-Direct Hire	Per Diem			\$221.24	
In Home Respite Per 15 minutes-Direct Hire	Per 15 minutes			\$4.51	
Individual Out of Home Respite Per Diem-Direct Hire	Per Diem			\$259.87	
Two Person In Home Respite Per Diem-Direct Hire	Per Diem			\$165.93	
Two Person Out of Home Respite Per Diem-Direct Hire	Per Diem			\$194.58	
Individual Supported Employment	Per 15 minutes	300	1400	\$15.42	\$6,476,400.00

State:	
Effective Date	

Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Group Supported Employment -Current Provider Rate	Per 15 minutes	1475	4000	\$2.89	\$17,051,000.00
Group Supported Employment -Current Provider Rate with Benefits	Per 15 minutes			\$3.03	
Independent Support Broker	Per 15 minutes	12	250	\$13.27	\$39,810.00
Adult Companion--Agency	Per 15 minutes	40	1600	\$4.49	\$287,360.00
Adult Companion-Direct Hire	Per 15 minutes	16	1600	\$3.25	\$83,200.00
Clinical Behavioral Support Services	Per 15 minutes	178	200	\$31.83	\$1,133,148.00
Continuous Residential Supports	Per Diem	3	352	\$290.46	\$306,725.76
Environmental Modifications	Per Service	6	1	\$8487.20	\$50,923.20
Family Training	Per 15 minutes	111	80	\$16.88	\$149,894.40
Health Care Coordination	Per 15 minutes	68	177	\$19.38	\$233,257.68
Individual Goods and Services	Per Service	4	8	\$106.09	\$3,394.88
Individualized Day Supports-Agency	Per 15 minutes	300	1350	\$8.54	\$3,485,700.00
Individualized Day Supports-Direct Hire	Per 15 minutes	90	1350	\$5.93	\$720,495.00
Individualized Home Supports-Agency	Per 15 minutes	1010	4800	\$8.54	\$41,401,920.00
Individualized Home Supports-Direct Hire	Per 15 minutes	107	2080	\$5.93	\$1,319,780.80
Interpreter-Current Provider Rate	Per 15 minutes	6	500	\$14.49	\$43,470.00
Interpreter-Language	Per 15 minutes	0	0	\$19.38	
Interpreter-American Sign Language	Per 15 minutes	0	0	\$12.21	
Nutrition	Per 15 minutes	12	16	\$19.38	\$3,720.96
Parenting Support	Per 15 minutes	40	800	\$13.72	\$439,040.00
Personal Emergency Response System-Installation	Per Unit	4	1	\$35.88	\$143.52
Personal Emergency Response System-Ongoing Monitoring-One Way	Per Month	0	0	\$29.90	
Personal Emergency Response System-Ongoing Monitoring-Two Way	Per Month	19	12	\$59.79	\$13,632.12
Personal Support-Agency	Per 15 minutes	675	1600	\$7.11	\$7,678,800.00
Personal Support-Direct Hire	Per 15 minutes	75	1600	\$5.93	\$711,600.00
Senior Supports-Agency	Per 15 minutes	7	5400	\$5.83	\$220,374.00
Senior Supports-Direct Hire	Per 15 minutes	3	3744	\$5.83	\$65,482.56
Specialized Medical Equipment and Supplies	Per Service	4	5	\$795.68	\$15,913.60
Transportation-Agency	Per Mile	695	1600	\$0.92	\$1,023,040.00
Transportation-Agency	Per Trip	75	200	\$31.52	\$472,800.00
Transportation-Wheelchair	Per Mile	6	1600	\$1.80	\$17,280.00
Transportation-Direct Hire	Per Mile	200	1600	\$0.45	\$144,000.00

State:	
Effective Date	

Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Vehicle Modifications	Per Service	3	1	\$7956.75	\$23,870.25
GRAND TOTAL:					\$103,667,977.55
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					4150
FACTOR D (Divide grand total by number of participants)					\$24,980.24
AVERAGE LENGTH OF STAY ON THE WAIVER					352

State:	
Effective Date	

